DOCUMENT RESUME

ED 210 850 EC 140 650

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TITLE Project C.H.A.N.G.E.: Concepts of Handicaps and Attitudes Need Guidance and Education. Teacher Training Program.
INSTITUTION Ridgeland Public Schools District 122, Oak Lawn, Ill.
SPONS AGENCY Bureau of Elementary and Secondary Education (DHEW/OE), Washington, D.C.
PUB DATE [81]
NOTE 306p.; For related documents, see EC 140 651-655.
AVAILABLE FROM Ridgeland Public Schools District 122, 6500 W. 95th St., Oak Lawn, IL 60453 ($20.00).

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Attitude Change; Audiovisual Aids; Curriculum Guides; *Disabilities; Elementary Education; Elementary School Students; *Inservice Teacher Education; Lesson Plans; *Peer Acceptance; Staff Role; *Student Attitudes; Student Evaluation; *Teaching Methods
IDENTIFIERS *Project CHANGE

ABSTRACT

The first of six volumes about Project CHANGE (Concepts of Handicaps and Attitudes Need Guidance and Education), a curriculum designed to improve elementary aged children's attitudes toward the disabled, presents information on installation and management of the inservice teacher training component, audiovisual materials for the teacher training program, and the content of the teacher training program. Part I provides role descriptions of project personnel (such as curriculum advisors, administrators, and special education teachers); a step by step procedure for scheduling, testing, and developing the parent volunteer primary testing team; and a step by step procedure for installing the teacher training program. Part II contains a section on utilization of overheads with many instructional pages appropriate for projection, and a section on utilization of audiovisual materials which is a compilation of materials listed by handicap with information on suppliers. The final part contains course materials (including lecture scripts, fact sheets, and handouts) for eight inservice training sessions focusing on the following topics: blindness, physical handicap, diabetes, mental retardation, learning disability, speech impairment, deafness, epilepsy, behavior disorders, rehabilitation and health careers, and methods of presenting the project curriculum to primary, intermediate, and junior high aged students. (DB)

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PROJECT CHANGE

CONCEPTS OF HANDICAPS AND ATTITUDES NEED GUIDANCE AND EDUCATION

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TEACHER TRAINING PROGRAM

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INTRODUCTION

The philosophy of Project C.H.A.N.G.E. (Concept of Handicaps and Attitudes Need Guidance and Education) is handicapped people have the right to be accepted as worthwhile individuals by their non-handicapped peers. Today, non-handicapped individuals are having increasing contact with handicapped individuals. Public Law 94-142 (The Education For All Handicapped Children Act) has added momentum to the growing rights movement of disability groups. However, increased rights for the handicapped population do not mean increased acceptance.

If handicapped individuals are to be successfully integrated into our schools, community, and society they must first be viewed and accepted as worthwhile individuals with the same feelings and needs as non-handicapped individuals. They must be viewed as being capable of sharing with non-handicapped individuals those experiences which constitute life.

Negative reactions towards people we perceive as different from ourselves are a common experience. We feel anxiety, fear, discomfort, or even hostility. Myths and stereotypes concerning these individuals are often incorporated into our value system. However, people do have the ability to change.

Attitudes are influenced by a variety of situational contacts with our family and society. Thus, it is possible for our attitudes to change or modify as a result of our experiences. The goal of Project C.H.A.N.G.E. is to influence and change those holding negative attitudes toward handicapped individuals. This is done by giving children a chance to acquire knowledge about handicapped individuals and their handicapping conditions. Knowledge will help to alleviate the common feelings of anxiety, fear, discomfort or hostility which non-handicapped individuals often experience when encountering a handicapped individual. Opportunity is provided for positive experiences with handicapped people which initiate the giant step towards positive attitudes.

Program teachers are an extremely important factor. They influence and foster knowledge and the attitude of acceptance in their students. They encourage their students to honestly examine and express their positive and negative feelings by creating an accepting atmosphere which develops student support. The expression and examination of positive and negative feelings by the student and the teacher is extremely important. The goal of the program is not to teach children to say "nice" things about handicapped people but to help them develop genuine feelings of acceptance for the disabled. Project C.H.A.N.G.E. deems it necessary to deal with positive and negative feelings as an initial step in successful program implementation and promotion of the ultimate goal - acceptance of the handicapped.

PROJECT
CONCEPTS OF HANDICAPS AND ATTITUDES NEED GUIDANCE AND EDUCATION
CHANGE

PART I

INSTALLATION AND MANAGEMENT OF THE TEACHER TRAINING PROGRAM

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTIONS

The following role description have been prepared for the designated personnel who will be implementing the Teacher Training Program at a demonstration site. Members of this team are responsible for fullfilling the tasks on their role descriptions. The designated coordinator is to supervise and assist task completion by each staff member on the team.

It is advisable for everyone on the staff to read all of the role descriptions of other team members as they may be able to provide assistance in the implementation of others' roles.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR COORDINATOR

The Coordinator will be responsible for the following:

1. Scheduling the dates and the Staff for participation in the Teacher Training Program.
2. Contacting outside speakers for presentations at the Teacher Training and student program.
3. Preparing the physical set-up of the training program location (equipment, films, etc).
4. Coordinating and ordering the audio-visual material for the training program sessions.
5. Maintaining records of attendance for the Teacher Training Program sessions.
6. Preparing and collating handouts for the participants in the training program.
7. Securing publicity releases from the staff speakers involved in the training program.
8. Participating in the Teacher Training Program by presenting and being responsible for one or more sessions.
9. Circulating program information to the staff and faculty participating in the program.
10. Assisting the Curriculum Advisors in grade level presentations of the curricula and assessment instruments.
11. Maintaining the testing schedule.
12. Arranging the site and time for teacher assessment instruments.
13. Providing appropriate packaging and dissemination of assessment instruments to the testing sites.
14. Monitoring testing situations.
15. Obtaining volunteers from the PTA and the community to serve as members of the Parent Testing Team.

16. Training the parent team in the use of the assessment instruments and scoring procedures.

17. Coordinating the Parent Testing Team in terms of scheduling, time sheets and transportation.

18. Preparing completed assessment instruments for delivery to the Project C.H.A.N.G.E. Producer.

19. Assisting the librarian with packaging of materials for teacher accessibility.

20. Scheduling the dates for the student program.

21. Organizing meetings with the designated staff.

22. Surveying local organizations and individuals for participation in program activities and compeling a list of these contacts for the resource file.

23. Revising forms for the project in conjunction with district needs and expansion of the program.

24. Disseminating material on the project to the School Board, PTA's or any other organization which requests information.

25. Coordinating staff octivities for implementation of the program.

26. Obtain a list of recommendations from the Staff on the strengths and weakness of the program. Submit a report of these findings to the Producer district.

27. Coordinate the "call-in" schedule of Teacher Manuals with the building principal.

28. Compile the teacher's Lesson Plan Checklist and Unit Evaluation forms for delivery to the Producer district.

29. Participate in an on-site follow up session with the Project C.H.A.N.G.E. Produce Personnel.

30. Process all purchase order slips and send them to the Producer District.

31. Maintain compliance of the District aggrement with Project: C.H.A.N.G.E.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR CURRICULUM ADVISORS

The Curriculum Advisor will be responsible for the followint:

1. Disseminating program assessment instruments to the classroom teachers, per the testing schedule.
2. Collecting testing instruments and score cards from classroom teachers per the testing schedule.
3. Participation in the Teacher Training Program by presenting and being responsible for one or more sessions.
4. Preparing and organizing handouts for sessions of the Teacher Training Program.
5. Assisting in the contacting and training of PTA members as the Parent Testing Team.
6. Presenting the curriculum and assessment instruments to the classroom teachers at the designated grade levels.
7. Assisting the librarian with program materials for teacher accessibility.
8. Assisting the coordinator in publicity releases for the program.
9. Contacting speakers for grade level presentations.
10. Monitoring examinations when needed.
11. Contacting local agencies for brochures, pamphlets and films.
12. Assisting the coordinator in any area of development that is necessary to the project.
13. Suggesting recommendations for improvement of the project and Curriculum to the Project C.H.A.N.G.E. Producer.
14. Attendance at staff meetings.
15. Assist in set-up of Teacher Training sessions.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR LIBRARIAN

The Librarian will be responsible for the following:

1. Inventory existing materials with the Project C.H.A.N.G.E. Media Assessment List. Report results to Project C.H.A.N.G.E. Producer.
2. Process and catalogue materials purchased for the program.
3. Package the project materials according to grade level and unit topics.
4. Distribute program materials to classroom teachers.
5. Participate in the Teacher Training Program by presenting and being responsible for one or more sessions including the curriculum session.
6. Prepare and organize handouts for sessions of the Teacher Training Program.
7. Assist in maintaining a record of attendance at the Teacher Training Program.
8. Setting up equipment which is necessary for the Teacher Training Program sessions.
9. Order and schedule films and other materials for use in Teacher Training Program and student curricula.
10. House materials, Media Assessment lists, and bibliographies in learning center.
11. Assist in set-up of Teacher Training Sessions.
12. Contact speakers for Teacher Training Program and student curricula.
13. Suggest recommendations for improvement of the project and curriculum to the Project C.H.A.N.G.E. Producer.
14. Attendance at Staff Meetings.
15. Assist in collecting publicity releases from district personnel involved in Teacher Training Program.

16. Establish a policy for replacement of materials which have been provided by Project: C.H.A.N.G.E.

17. Inventory all program materials.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR ADMINISTRATOR

The Administrator will be responsible for the following:

1. Participation in the Teacher Training Program by presenting and being responsible for one or more sessions.
2. Preparing and organizing handouts for sessions of the Teacher Training Program.
3. Assisting the librarian with program materials for teacher accessibility.
4. Attendance at Staff Meetings.
5. Developing publicity releases for the project.
6. Contacting and scheduling Speakers for the Teacher Training Program.
7. Assisting the Coordinator in the physical aspects of the Teacher Training Program (location, equipment, etc).
8. Monitoring examinations when needed.
9. Assisting the Curriculum Advisor in grade level presentation of the curricula and assessment instruments.
10. Suggesting recommendations for the improvement of the project and the curricula to the Project C.H.A.N.G.E. Producer.
11. Assisting the Coordinator by disseminating material and information to other staff members.
12. Maintain a record of attendance at the Teacher Training Program.
13. Collect publicity releases from district personnel involved in training program.
14. Maintain compliance of the district agreement with Project C.H.A.N.G.E.
15. Establish a policy on replacement of materials provided by Project: C.H.A.N.G.E.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR SPECIAL EDUCATION TEACHER

The Special Education Teacher will be responsible for the following:

1. Participation in the Teacher Training Program by presenting and being responsible for one or more sessions.
2. Preparing and organizing handouts for sessions of the Teacher Training Program.
3. Assisting the librarian with program materials for teacher accessibility.
4. Monitoring examinations when needed.
5. Attendance at Staff Meetings.
6. Contacting speakers for grade level presentations.
7. Compiling information from local service agencies for the resource file.
8. Assisting the Curriculum Advisors in presenting the curricula and assessment instruments to the classroom teachers.
9. Suggesting recommendations for the improvement of the project and curriculum to the Project C.H.A.N.G.E. Producer.
10. Attending conferences and conventions on project related topics and disseminating pertinent information to staff and teachers.
11. Assist in set-up of Teachers Training session.

PROJECT: C.H.A.N.G.E.
TITLE IV C

ROLE DESCRIPTION FOR NURSE

The School Nurse will be responsible for the following:

1. Participation in the Teacher Training Program by presenting and being responsible for one or more sessions.
2. Preparing and organizing handouts for sessions of the Teacher Training Program.
3. Explore various community ortanizations for availability of material and speakers to update resource file.
4. Assist in obtaining and scheduling speakers for student program.
5. Attendance at staff meetings.
6. Assist the coordinator in publicity releases and public relation activities of the program.
7. Suggest recommendations for improvement of the project and curriculum to the Project C.H.A.N.G.E. Producer.
8. Attend all available Nursing and Medical workshop on program subjects and relate information on current material and strategies to staff.
9. Assisting the curriculum Advisors in presenting the curricula and assessment instruments.
10. Assist in set-up of Teachers Training sessions.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

OVERVIEW OF SCHEDULING

This section incorporates a series of forms in a step-by-step procedure which has been designed to ease the installation process of the program. The timeline for the student and teacher training program must be determined prior to completing the scheduling forms. Suggested timelines are discussed in this section.

Samples have been provided to assist the training staff in completing the fill-in-the-blank forms. This scheduling section focuses on the student program, the teacher training program, the testing schedule and the evaluation process. A colorcoded system in yellow has been designed to aid the training staff in completing the required forms.

A portion of this section has been devoted to the implementation of the primary testing team. Forms for this section are colorcoded in green as their distribution is to volunteers from organizations or agencies. The colorcode was changed from yellow as these forms are for distribution outside of the school district.

The portions on student and teacher program scheduling are mandatory for all adopters. The portion on test scheduling the evaluation process and the development of the primary testing team are required only for districts which have elected to participate in the data collection process.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

Distribution: Classroom Teachers,
Principal, Librarian

Step I - Scheduling the Student Program

Scheduling the student curriculum is a vital step in the planning process of the program. The student schedules effect the testing dates and the obtaining of guest speakers for the program. In order to establish dates it is necessary to have a copy of the school district calendar (a sample follows).

The time of the year the program is to be implemented should be decided before scheduling. Recommended times blocks for implementing the program are:

1) September through May
2) October through February
3) January through May

The most important factor in selecting a timeline is that the time selected should be the best and most convenient for the teachers in your district to implement the program. In the first year, the teacher training program must be completed (and all teacher testing done) prior to implementation of the student program.

Once the timeline is established, the dates each unit is to be taught must be determined. Make a chart writing the unit titles in a vertical column and the weeks the lessons are to be taught in a similar column. The dates are to be verified using the school calendar so units are not scheduled over vacation, or to begin on a holiday, institute, etc.

Six schedules must be done for the grades as listed below:

1) kindergarten through third
2) fourth grade
3) fifth grade
4) sixth grade
5) seventh grade
6) eighth grade

Note that the schedules for fourth through seventh grade lessons will have the same dates for teaching, however, the unit topics change at each grade level. Doing the schedule for each grade level prevents confusion on the part of the teacher.

Samples of the kindergarten through third grade program schedule and the fourth grade schedules follow as a reference.

SCHOOL CALENDAR
1979-80

SCHOOL DISTRICT 122
OAK LAWN, ILLINOIS

SAMPLE

AUGUST-SEPTEMBER				
㉗	28	29	30	31
~~3~~	4	5	6	7
10	11	12	13	14
17	$\boxed{18}$	19	20	21
24	25	26	27	28
OCTOBER				
1	2	3	4	5
~~8~~	9	(10)	11	(12)
15	16	17	$\boxed{18}$	19
22	23	24	25	26
29	30	31		
NOVEMBER				
			1	②
5	6	7	8	9
12	13	14	15	16
19	20	21	~~22~~	~~23~~
26	27	28	29	30
DECEMBER				
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
~~24~~	~~25~~	~~26~~	~~27~~	~~28~~
~~31~~				
JANUARY				
	~~1~~	~~2~~	~~3~~	~~4~~
7	8	9	10	11
14	15	16	17	$\boxed{18}$
21	22	23	24	25
28	29	30	31	-
FEBRUARY				
				1
4	5	6	7	8
⑪	~~12~~	13	14	15
18	19	20	21	22
25	26	27	28	29
MARCH				
3	4	5	6	7
10	11	12	13	14
17	18	$\boxed{19}$	20	21
24	25	26	27	28
31				
APRIL				
	1	2	3	~~4~~
~~7~~	~~8~~	~~9~~	~~10~~	~~11~~
14	15	16	17	18
21	22	23	24	25
28	29	30		
MAY				
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
~~26~~	27	28	29	30
JUNE				
2	3	*4	*5	*6
*9	*10	~~11~~	~~12~~	~~13~~

X .. Legal Holidays - No School
0 .. Institute Days - No School
== .. Not in Attendance
☐ .. Half-Day Workshops-No School-Noon-3
( ).. Open House
* .. Non-Attendance-emergency days only

8/27 - Breakfast Orientation Institute- No School
8/28 - First day for students 9-10 a.m.
9/3 - Labor Day - No School
9/18 - Half-Day Workshop - No School - Noon-3:00(Elem.Eng. & Dept.Meet. J.H.)
10/8 - Columbus Day - No School
10/10 - Open House - Simmons Jr. High
10/12 - Open House - CM-DH-H-L
10/18 - Half-Day Workshop - No School Noon-3 (Behavior Management)
11/2 - Institute (Parent Conference)No School
11/12/16-Parent Visitation Week
11/22/23 - Thanksgiving Holiday - No School
12/21 - Christmas Holiday begins at Close of Day
1/7 - Classes Resume
1/18 - Half-Day Workshop - No School - Noon-3:00 (Learning Resource Center)
2/11 - Institute (Visitation) - No School
2/12 - Lincoln's Birthday - No School
3/19 - Half-Day Workshop - No School - Noon-3:00 (Project C.H.A.N.G.E.)
4/4 - Good Friday - No School
4/7 to 4/11-Easter Vacation - Classes not in Session
4/14 - Classes Resume.
5/26 - Memorial Day - No School

June 4, 5, 6, 9, 10 will be declared non-attendance days if not used for emergency days. School year, then would officially end on June 3, 1980.

EARLY DISMISSAL: 2:00 p.m. (Students)

10/30 1/15 3/18 5/27

REPORT CARDS ISSUED

K-8 11/2 1/18 3/21 6/3

END OF MARKING PERIODS

K-8 10/26 1/11 3/14 5/23

Approved by the Board of Education 122
Date: March 5, 1979

SAMPLE

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA
K-3 PROGRAM SCHEDULE
SEPTEMBER 1980 THRU FEBRUARY 1981

TESTING	**WEEK OF:**
Skill Attainment List (Kindergartens - Parent Team)	9/15/80 thru 9/19/80

UNITS	
Normal Health	1. 9/22/80 thru 9/26/80
	2. 9/29/80 thru 10/3/80
	3. 10/6/80 thru 10/10/80
Senses	1. 10/13/80 thru 10/17/80
	2. 10/20/80 thru 10/24/80
	3. 10/27/80 thru 10/31/80
Acceptance of Individual Differences	1. 11/3/80 thru 11/7/80
	2. 11/10/80 thru 11/14/80
	3. 11/17/80 thru 11/21/80
Blindness	1. 11/24/80 thru 11/26/80
	2. 12/1/80 thru 12/5/80
	3. 12/8/80 thru 12/12/80
Deafness	1. 12/15/80 thru 12/19/80
	2. 1/5/81 thru 1/9/81
	3. 1/12/81 thru 1/16/81
Physical Handicaps	1. 1/19/81 thru 1/23/81
	2. 1/26/81 thru 1/30/81
	3. 2/2/81 thru 2/6/81
Acceptance of Handicaps	1. 2/9/81 thru 2/11/81
	2. 2/16/81 thru 2/20/81
	3. 2/23/81 thru 2/27/81

TESTING	
Skill Attainment List All K-3 Parent Team	2/23/81 thru 2/27/81

SAMPLE

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA
GENERAL SCHEDULE - GRADE 4
SEPTEMBER 1980 THRU FEBRUARY 1981

TESTING	**WEEK OF:**
Skill Attainment List (Teacher Given)	9/15/80 thru 9/19/80
UNITS	
Acceptance of Self & Others (Handicapped & Non-Handicapped)	9/22/80 thru 9/26/80
	9/29/80 thru 10/3/80
	10/6/80 thru 10/10/80
Physiology of the Eye	10/13/80 thru 10/17/80
	10/20/80 thru 10/24/80
	10/27/80 thru 10/31/80
Blindness	11/3/80 thru 11/7/80
	11/10/80 thru 11/14/80
	11/17/80 thru 11/21/80
	11/24/80 thru 11/26/80
	12/1/80 thru 12/5/80
Physiology of the Endocrine System	12/8/80 thru 12/12/80
	12/15/80 thru 12/19/80
	1/5/81 thru 1/9/81
Diabetes	1/12/81 thru 1/16/81
	1/19/81 thru 1/23/81
	1/26/81 thru 1/30/81
	2/2/81 thru 2/6/81
	2/9/81 thru 2/11/81
TESTING	
Skill Attainment List (Teacher Given)	2/16/81 thru 2/20/81

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: School Administrators,
Principals,
Past one copy at each building for teaching staff

Step I - Scheduling Testing Dates - Form 1

In order to establish testing dates it is necessary to have a copy of the Student Program Schedule and the teacher training program dates. Dates for pretesting (before the program starts) and posttesting (at the end of the program) the experimental and control groups (teachers and students) must be established. A sample copy of a completed schedule (Instrument Administration Chart) along with a brief description of the assessment instruments follows for your reference.

The Instrument Administration Chart (form 1) has been provided for your convenience. Look at the dates of the Teacher Training Program and select one day prior to the training for your pretest date. After the date has been selected insert this information under the vertical column labeled Pre-Date(s) in line with the horizontal column labeled K-8 Teachers. The same procedure follows for the post-date of the teacher training program.

Scheduling the fourth through eighth grade students is the next step. These schedules are easier to do than the primary ones as they are teacher administered and not dependent upon a separate testing team. At the fourth through eighth grade, classroom teachers are allotted a five day period for testing. This amount of time is allowed for the convenience of the teacher. Teachers may test any day they desire during this period.

Look at the beginning date of the student program for grades four through eight. Put the beginning and ending date of the school week which precedes the program into the Pre-date(s) column across from the 4-6 students and the 7-8 students boxes. The same procedure is to followed for the selection of the Post-Date(s). Posttesting is to occur the week after the program has ended.

The kindergarten through third grade students are tested by the primary team not the classroom teacher. For each building that has primary students (K-3) participating in the program one day for testing is to be selected. On that day the primary team will test the students using both the Primary Skill Attainment List and the Primary Attitude Survey. A complete description for developing the primary testing team follows this section.

SAMPLE

DISTRICT 122
EXPERIMENTAL AND CONTROL
BUILDINGS

PROJECT: C.H.A.N.G.E.
TITLE IV C – ESEA
INSTRUMENT ADMINISTRATION CHART

SUBJECTS	INSTRUMENTS	PRE-DATE(S)	POST-DATE(S)
K-8 Teachers	1. Survey of Disabilities 2. Attitude Toward Disabled Persons (ATDP) ½ hour	8/28/80	9/17/80
K-3 Students	1. Skill Attainment List 2. Primary Attitude Survey (Parent team)		
	Harnew – Experimental	9/18/80 (Th)	2/23/81 (M)
	Columbus Manor – Experimental	9/19/80 (F)	2/24/81 (T)
	Lieb – Control	9/22/80 (M)	2/26/81 (Th)
	Dearborn Hts. – Control	9/23/80 (T)	2/27/81 (F)
4-6 Students Experimental & Control	1. Skill Attainment List 2. Intermediate Attitude Survey (Teacher Administered)	9/15/80 (M) thru 9/19/80 (F)	2/16/81 (M) thru 2/20/81 (F)
7-8 Students Experimental and Control	1. Skill Attainment List 2. Jr. High Attitude Survey (Teacher Administered)	9/15/80 (M) thru 9/19/80 (F)	2/16/81 (M) thru 2/20/81 (F)

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PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

ASSESSMENT INSTRUMENTS

Districts who have agreed to test in their Statement of Joint Application must establish both an experimental and control site within their district. The experimental groups of teachers and students participate in the following design:

PRETEST - INTERVENTION - POSTTEST OF TEACHERS OR STUDENTS

The teachers and students who are designated as the control groups will participate in the following design:

PRETEST - NO INTERVENTION - POSTTEST

The assessment instruments for the Project C.H.A.N.G.E. curricula were designed to measure the growth of student knowledge and attitudinal changes in terms of the unit objectives and concepts. All assessment instruments have a script, an examiner's record sheet, and score cards. The script describes the administration procedures. The examiner's record profiles identifying information on the class. Score cards are used to record the responses. Each instrument is described below according to it's function and target groups.

TEACHER INSTRUMENTS

Survey of Disabilities

The Survey of Disabilities is a timed (no more than 30 minutes) fifty item multiple choice (four option) group instrument designed to measure the specific areas of disabilities covered in the curriculum.

Attitude Toward Disabled Persons (ATDP)

The ATDP is a thirty item six choice group questionnaire designed to measure attitudes toward disabled persons as a group.

STUDENT INSTRUMENTS

Primary Attitude Survey

The Primary Attitude Survey is an individual multiple choice (5 option) thirty item instrument designed to provide an estimate of a non-handicapped subject's attitude toward handicapped individuals. A non-verbal-motor response (pointing to the picture plate) is the only requirement of the subject. This instrument is not timed but generally requires seven minutes per child, after the pre-training session.

The Primary Attitude Survey is most efficiently administered by a team consisting of parent, volunteers who are trained by the staff.

Skill Attainment List - Primary Grades

The Skill Attainment List is an individual twenty-eight item checklist designed to measure the student's cognitive gains in terms of grade level objectives and concepts. An oral response is required of the subject. The most effective manner of administration is using a team consisting of parent, volunteers who are trained by the staff.

Intermediate Attitude Survey - Grades 4-6

The Intermediate Attitude Survey is a thirty item four choice group questionnaire administered by the classroom teacher.

This instrument is designed to measure attitudes of non-handicapped students toward handicapped individuals in the following areas:

I. physical appearance
II. personality traits
III. expectancy
IV. marriage
V. emotional capabilities

Junior High Survey - Grades 7-8

The Junior High Attitude Survey is a twenty-five item four choice group questionnaire administered by the classroom teacher.

This instrument is designed to measure attitudes of non-handicapped students toward handicapped individuals in the following areas:

I. physical appearance
II. personality traits
III. expectancy
IV. marriage
V. emotional capabilities

Skill Attainment List - Grades 4-8

The Skill Attainment List is a group multiple choice (4 option) thirty item instrument designed to measure the concepts of the curriculum objectives at each grade level. The instrument is administered by the classroom teacher.

Presenting Assessment Instruments

School districts using the assessment instruments will explain the process to their staff in session #8 of the Teacher Training Program. This information is session #8 is presented prior to small group discussions on the curriculum. Overhead transparencies have been provided to assist the trainers in explaining test procedures. Districts who are not involved in testing need not explain the procedure.

Evaluation

In testing districts, the lesson plan checklist and the unit evaluation form are to be completed by the experimental teachers. These sheets are also described in session #8 and have accompanying transparencies.

Lesson Plan Checklist

This form is located at the end of each unit. Write the title of the lesson plan which was taught on the line provided next to the appropriate date or week. The rating code which appears on this form is to be used in evaluating the activity. The Lesson Plan Checklist was designed as an evaluation to aid the Producer school in revising lessons.

Unit Evaluation Form

The Unit Evaluation Form is located at the end of each unit. This form should be completed at the conclusion of each unit. Select one lesson which was taught and evaluate it on this form. Write the Unit title on the line provided. (e.g.-Senses-Kdg.). The Activity title which is found on the lesson. (e.g.-Hand, Hand Hand, Game). Next to the Objective write the objective as it is stated on the lesson plan. (The students can identify various body parts).

The Outcome refers to the student's reaction, the teacher's reaction, and pertinent comments about the lesson. (Students enjoyed this activity as they are able to be physically active).

Next to Evaluation state simply whether or not the lesson was successful in implementing the objective. (The lesson met the objective). Under the Evaluation of Activity answer the three questions. The Unit Evaluation Form assists the Staff in improving the program.

Form 1

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA
INSTRUMENT ADMINISTRATION CHART

SUBJECTS	INSTRUMENTS	PRE-DATE(S)	POST-DATE(S)
K-8 Teachers	1. Survey of Disabilities 2. Attitude Toward Disabled Persons (ATDP)		
K-3 Students	1. Skill Attainment List 2. Primary Attitude Survey (Parent team)		
4-6 Students Eperimental & Control	1. Skill Attainment List 2. Intermediate Attitude Survey (Teacher Administered)	Week of:	Week of:
7-8 Students Experimental & Control	1. Skill Attainment List 2. Jr. High Attitude Survey (Teacher Administered)	Week of:	Week of:

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

EVALUATING THE STUDENT PROGRAM

Evaluation is a vital component of the program. During program implementation, evaluation is an ongoing process. On the following pages a step-by-step procedure for evaluating the program is presented.

The yellow color coding format for district distribution is continued in this section for easy identification. It is the responsibility of your school district to reproduce the two evaluation forms and distribute them to the experimental teachers. This element of the program is mandatory for testing school districts. It is an important option for non-testing districts to evaluate the project's effectiveness within their district.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: All Experimental Teachers

Step 1 - Form 1

The first step in the evaluation process is to use form 1, the Lesson Plan Checklist. The teacher should write the grade level and the title of the unit which is being studied in the space provided.

Using the grade level program schedule as a guide, the date of the lesson and the title should be recorded. A code for rating each activity is provided on the Lesson Plan Checklist.

Testing districts are to collect the Lesson Plan Checklists at the end of the student program and return these forms to the producer district. Districts who are not participating in testing may wish to have the teacher's responses evaluated by the principal or curriculum coordinator.

Experimental teachers at the primary level (K-3) will need seven copies of the Lesson Plan Checklist. Teachers at the intermediate (4-6) and the seventh grade teachers will need five copies. The eighth grade teachers will need four copies of the form as the Review of Disabilities and Rehabilitation unit requires two forms.

FORM 1

LESSON PLAN CHECKLIST

______ GRADE CURRICULUM

RATE THE ACTIVITY USING THIS CODE:

E - EXCELLENT
VG - VERY GOOD
G - GOOD
P - POOR
N/A - NOT APPROPRIATE

UNIT TITLE: ______________________________

DATE:	ACTIVITY TITLE	ACTIVITY RATING				
		E	VG	G	P	N/A
__________	____________________	4	3	2	1	0
__________	____________________	4	3	2	1	0
__________	____________________	4	3	2	1	0
__________	____________________	4	3	2	1	0
__________	____________________	4	3	2	1	0

AFTER COMPLETING THIS UNIT, TAKE ONE ACTIVITY AND EVALUATE IT ON THE UNIT EVALUATION FORM
A UNIT EVALUATION MUST BE DONE FOR EACH UNIT.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: All Experimental Teachers

Step 2 - Form 2

The second step in the evaluation process is the completion of form 2, the Unit Evaluation Form. After each unit is completed, the teacher is to select one lesson from the unit and evaluate it using this form.

The Unit Evaluation Form is required for testing districts and is to be returned to the producer district with the Lesson Plan Checklists at the end of the student program. In non-testing districts, this form should be reviewed in conjunction with the Lesson Plan Checklist.

Teachers at the primary level will need seven forms. Teachers at the intermediate and seventh grade level will need five forms. Eighth grade teachers will require three forms.

Y

PROJECT: C.H.A.N.G.E.

TITLE IV C ESEA

UNIT EVALUATION FORM

UNIT TITLE ____________________

ACTIVITY TITLE ____________________

OBJECTIVE ____________________

OUTCOME: (STUDENT'S REACTION, COMMENTS, TEACHER'S REACTION) ______

____

____

EVALUATION: (IN TERMS OF OBJECTIVE) ____________________

____

____

EVALUATION OF ACTIVITY:

1. IF USED AGAIN, WHAT WOULD YOU CHANGE? ____________________
   ____
2. IF USED AGAIN, WHAT WOULD YOU RETAIN? ____________________
   ____
3. WHY DID YOU CHOOSE TO EVALUATE THIS ACTIVITY? __________
   ____

FORM 2

DEVELOPING THE PRIMARY TESTING TEAM

This section will prepare the training staff to establish a primary testing team. The primary testing team is a volunteer group of parents or interested community members who are trained to administer the Primary Skill Attainment List and the Primary Attitude Survey.

Both tests at the primary level (kindergarten through third grade) are individual instruments. It generally requires fifteen minutes with each child to complete both instruments. Thus the primary testing team was developed to save the valuable time of the classroom teacher.

On the following pages a step-by-step procedure for the development of the primary testing team is presented. Sample forms and fill-in-the blank forms have been designed to assist the staff. Forms which are to be distributed to the members of the primary test team are colorcoded in green for easy identification. All information in your school district policy which refers to volunteer workers should be noted prior to developing the primary testing team.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: Primary Testing Team,
Superintendent, Principals
Primary Teachers

STEP 1 - FORM 1

The first form is entitled the Primary Team Testing Schedule. In order to develop the primary team it is necessary to first complete this form. The information on dates, day, school and grade needed for this form can be found on your district testing schedule.

It will be necessary to contact your building principals to ascertain the number of rooms at each grade level and the time that their buildings can be tested. This form must be completed before preceding to contact outside groups for volunteers to test as this information is vital in scheduling the primary testing team.

Note: A completed copy of form 1 is sent with form 3 to potential testors.

G

PROJECT: C.H.A.N.G.E.

PRIMARY TEAM
TESTING SCHEDULE

DATE	DAY	SCHOOL	GRADE	NO. OR ROOMS	TIME

Form 1

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: P.T.S.A, community groups, local high schools or colleges

STEP 2 - FORM 2

This form is a letter of introduction and inquiry which requests the assistance of local community groups in developing a primary testing team.

Please remember to duplicate this letter on your district's letterhead stationery and to fill in the section on who respondents are to contact.

Dear ________________,

This year our school district is introducing a new program into the student curricula. Project: C.H.A.N.G.E. (Concepts of Handicaps and Attitudes Need Guidance and Education) is a Title IV C Elementary Secondary Education Act program. Title IV C programs are supervised and developed over a three year period to meet crucial needs of school districts in the state of Illinois.

Project C.H.A.N.G.E. is a unique program which provides knowledge of disabilities to the non-handicapped student and teacher in order to promote acceptance of the handicapped. One of the objectives of the program is to measure students knowledge and attitudes. This is done before the students start receiving lessons on the disabilities and after the students have completed their lessons.

Your organization is being contacted in the hopes that some of your members would participate in this testing program. Volunteers are being sought to assist in the testing of children from kindergarten through third grade. Our district feels this program will help our children, educationally and attitudinally, if you have anyone who is interested please have them contact:

Yours truly,

Trainer Coordinator

Distribution: Primary Team
Applicants

STEP 3 - FORM 3 and FORM 1

When contacted by a person who is interested in working on the primary testing team. Obtain the appropriate information (name, address, zip) and send them an availability questionnaire (Form 3) and the Primary Testing Team Schedule (Form 1). Tell all interested parties to complete the availability questionnaire and to make a note of the days on the primary team testing schedule of when they are able to test. Tell them a short meeting will be scheduled several days prior to testing to acquaint them with the instruments. A letter will be sent informing them of the time, day and place of the training meeting. Both forms 3 and 1 are to be brought to the training meeting.

Under the words Project: C.H.A.N.G.E. on form #2, fill in the identifying information for your district on the lines provided. Responses should be kept in a file labeled Primary Testing Team, as it will be necessary to refer to this information several times during the year.

Any other forms which must be completed by the primary team due to your district policy can be sent to respondents along with forms 3 and 1.

G

PROJECT: C.H.A.N.G.E.
PRIMARY TESTING TEAM
AVAILABILITY QUESTIONNAIRE

IF YOU'D LIKE TO WORK AS A MEMBER OF THE PRIMARY TESTING TEAM, PLEASE FILL OUT THIS FORM IMMEDIATELY AND RETURN TO:

PROJECT: C.H.A.N.G.E.
____
____
____
____
____

NAME ____

ADDRESS ____

PHONE ____

ORGANIZATION ____

AVAILABILITY: (PLEASE CHECK) TIME

A.M. TESTING ______________________________

P.M. TESTING ______________________________

BOTH _____

Form 3

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: Primary Team Members

STEP 4

On the following page a sample letter informing the primary team members of the training session is shown. Please read this before designing your own letter.

The letter from your school district should:

1) be on school district stationery
2) include the day, date, time and place of the meeting
3) have a complete address and a telephone number in case someone finds it necessary to call for directions.

The map which is used for speakers coming to your district can accompany your letter. After all responses are in compose a Team Member Directory,, (include names, addresses and phone numbers of all team members). A School Information List containing the name of each school, address, phone and contact person (principal, etc) should also be prepared.

Form #4 - Testing Schedule

Fill in the appropriate information; under building, put the name of the school, under date/day, put the days you are testing and under classes, the number of rooms which have to be tested. This information must be decided prior to the primary team training session. At the meeting, the number of classrooms to be tested will determine the number of volunteer testors who will be needed.

SAMPLE

Project C.H.A.N.G.E.

Title IV C ESEA
Concepts of Handicaps and Attitudes Need Guidance and Education

DONALD W. MARTIN, Director
SHERRY SMITH, Coordinator
ROBERT L. OLCESE, Superintendent
DR. DONALD R. JOHNSON,
Assistant Superintendent and Business Manager

December 8, 1980

Dear Mr. Jones,

On Monday, December 15, 1980, there will be a short meeting at 10 A.M. in the Project: C.H.A.N.G.E. office at Harnew School for the Primary Testing Team.

Please bring your availability questionnaire and the Primary Testing Team Schedule at this time. We will discuss the working days and have a short training session on the Primary Attitude Survey and the Skill Attainment List which we will be administering to the children.

Thank you for your interest in our program.

Yours truly,

S. Smith
Coordinator

SS/lgc
enclosure

Project C.H.A.N.G.E. • Harnew School • 9100 South Austin, Oak Lawn, Illinois 60453 • (312) 599-2263

G

TESTING SCHEDULE

BUILDING	DATE/DAY	# OF CLASSES	TEAM MEMBER	PHONE

Distribution: Primary Team

STEP 5 - THE TRAINING SESSION FOR PRIMARY TEAM MEMBERS

TIME: 1 hour or less

Materials: Form 5 - Role description for team members
Primary Skill Attainment List and Score Card
Primary Attitude Survey and Score Card
Picture plate for Attitude Survey
Pre-training plate for Attitude Survey
Team Directory
School Information List
Form #4 - testing schedule

AGENDA

1) Introduce the team members to one another
2) Distribute Form #5 (Role Description for Team Members)
3) Go over this form and answer all questions.
4) Distribute the Primary Attitude Survey, plate and score cards. Go through this instrument orally with the team. Describe items on picture plate and explain scoring. Acquaint all members with pre-training plate and the proper procedure. Answer all questions.
5) Distribute the Primary Skill Attainment List and score card. Go over the directions orally and read through instrument and appropriate responses. Explain scoring procedure. Answer all questions.
6) Distribute the Team Directory and the School Information List. Check information to see if it is accurate.
7) Using Form #5 schedule members for testing. If the number of classes to be tested on a specific day is small, remember you will need fewer testors. The reverse applies if there are many rooms you'll need more testors.
8) Tell team members, they may take the instruments home to review them. Remind all to be prompt for their testing days.
9) When testing is completed, it is suggested that each volunteer receive a thank you note.
10) Form #6 prior to testing send the principal a reminder of the day/s the team will be in the building.

ROLE DESCRIPTION FOR PRIMARY TEAM MEMBER

The tester will be responsible for the following:

1. Attending training sessions to learn the administration of the Primary Skill Attainment List and the Primary Attitude Survey.
2. Reporting promptly to schools on days designated for testing.
3. Informing the Project Coordinator of inability to work on any day so that a substitute can be arranged.
4. Administering Project C.H.A.N.G.E. test instruments to children between kindergarten and third grade participating in the program.
5. Accurately recording responses of the children tested and returning the data to the Project Coordinator.

Dear Principal,

Please remind your K-3 teachers that on , the primary testing will be administering two tests to each child on an individual basis. A testor will come to their room for the children when it is their turn to be tested.

Thank you,

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

Distribution: Principal, Custodian

STEP 6 - REQUIREMENTS FOR PRIMARY TESTING TEAM

To efficiently test a building it is necessary that the following items be prepared for the team.

1) pencils for each testor and extra test copies
2) test packages labeled with teachers name, grade and title of test
    a. class list
    b. score card for each student
3) a room for testing
4) a desk and chair for each testor
5) a chair for the student

OVERVIEW OF THE TEACHER TRAINING PROGRAM

FORMAT OF THE TEACHER TRAINING PROGRAM

The teacher training program is divided into eight sessions. A course outline describing the instructional objectives for each session follows this overview. These sessions are concerned with the causes and problems of the disabilities which comprise the instructional units of the student curricula. The training sessions are available in script for reading at a live speaker presentation program or on video tape/audio cassettes.

Each session of the training program includes:

1. Outline
2. Script
3. Vocabulary list
4. Fact Sheet
5. Reference Sheet

and 6. Handouts.

The outline provides the order in which the information from the script will be presented. The script is in a lecture format. It covers the designated cognitive material on each topic which will enable the teacher to implement the student curricula. The vocabulary list provides a definition of terms appropriate to the script. A fact sheet contains the core material of the script. The reference sheet lists the sources from which the material in the script were acquired. Handouts provide additional supportive information which can be used by the teacher when implementing the student curricula.

A color coded system has been formulated for material which is to be distributed to the teacher during the training program. All blue sheets are to be given to teachers who will instruct students in the project curricula. The color coded sheets are: the outline, vocabulary list, fact sheet, reference sheet and handouts.

SEQUENCE OF SESSIONS

Sessions are arranged in a predesignated order which best accomplishes the over-all goal of the program. Session #1 focuses on the disabilities of blindness and physical handicaps. These topics are presented first as they are physically observable handicapping conditions. From the point of exposure, the concrete sense loss involved in these disabilities is readily observed in school and community. These topics are presented in at each grade in the primary program. Blindness is a major unit in the fourth grade and physical handicaps is studied in the sixth grade curricula.

Diabetes is the only topic presented in session #2. Its placement is associated with both of the topics (blindness and physical handicaps) introduced in session #1. Diabetes is the number one cause of blindness. A relationship also exists between diabetes and physical handicaps. A percentage of the amputees in our society lost their limbs as a result of being diabetic. Diabetes is a difficult topic for the non-medical person to understand. An enormous amount of the material is complex in nature and requires the undivided attention of those teachers who will be implementing the program at the fourth and eighth grade levels.

The third session presents mental retardation and learning disabilities; topics which were paired in order to show their sharply contrasting characteristics. It is extremely important for teachers to understand the differences in general level of intelligence which exist between these two groups, while at the same time recognizing possible areas of overlap. The seventh and eighth grade curricula examine these disabilities.

Speech impairments and deafness are discussed in session #4. These topics were selected for discussion in the same session in order to show their cause/effect relationship. Most deaf individuals have or have had a speech impairment. This strong correlation and overlapping information on the communication system is more understandable when presented as a unit. Deafness is studied in all levels of the primary curricula, however deafness and speech impairments are the two disabilities studied in the fifth grade curricula.

The primary reason for selecting epilepsy as the only topic of session #5 was the difficulty a non-medical person would have in understanding the complex terminology and related symptoms. The material discussed in this session describes the types of seizures and avenues of first aid for epileptics. It is important for those teaching the sixth and eighth grade curricula to understand the material presented in this session.

In session #6 the theoretical basis of behavioral disorders and the educators role in rehabilitation are presented. The emotional problems unit which is studied in seventh grade was formulated from the material presented in this session.

The terms behavior disorders and emotional problems are synonomous in the educational arena. After much deliberation the seventh grade unit was entitled emotional problems. The justification for this title selection lies in the fact that most school districts label self-contained classrooms for "problem" children as behavior disorded classes. It was felt the use of this title in the student program might encourage students to start labeling more readily than they do now.

Rehabilitation services and health careers are correlated topics which are presented in session #7. It is important not only to understand the restoration (rehabilitation) and daily functioning (careers) of the disabled but also the relevance these areas have for the non-handicapped. Teachers implementing the eighth grade curricula must familiarize themselves with the information presented in this session.

The concluding session (#8) is the presentation of the curricula. The teachers will become familiar with assessment instruments and operating procedures of the Teacher Training Manual for Implementation of the Project C.H.A.N.G.E. Curriculum at their respective grade levels. The eight sessions of the Teacher Training Program build the necessary foundation of knowledge which culminates in teaching the curriculum.

INSTALLING THE TEACHER TRAINING PROGRAM

This section will prepare the training staff in the uses of forms, contacting speakers and establishing contact with local agencies or resources for the program. The Teacher Training Program is available in script (for staff reading with guest speaker presentations), on video tapes or on audiocassettes.

The preferred format (Format 1) is the staff reading the designated script while incorporating Audio Visual materials and guest speakers who are disabled or represent an agency concerned with the disabled. This type of presentation was designed for teachers to complete one two hour session per week for a period of eight weeks resulting in sixteen hours of training.

The video tape (Format 2) and audio cassettes (Format 3) program should include guest speakers and additional audio visual materials wherever possible. As most teachers are not thoroughly familiar with all of the information available on disabling conditions, it is necessary to have supplemental material available. When using the video and audio format it is advisable to have scripts available for those teachers who wish to consult them. All handouts are given to teacher when using either of these formats.

A step-by-step procedures is followed and the formats for which the material is applicable are indicated. Forms have been designed for the staff to use through a fill-in-the-blank technique. These forms are colorcoded in yellow and should ease the distribution process to staff and faculty members.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP I - FORM I DISTRIBUTION: Project Staff and Faculty

The first form describes the testing schedule and indicates the buildings which are involved as experimental and control. This is a general information bulletin which is distributed to both the experimental and control staff.

This form also introduces the designated school district staff and informs the teachers of the forthcoming Teacher Training Program. Information to fill this form in should be obtained from the Superintendant.

USE FOR FORMATS: 1, 2, 3

The only exception (which could incur involving this form) is that if no testing is to occur in your district, this form shuld be revised by the coordinator eliminating the references to experimental-control groups and data collection.

PROJECT: C.H.A.N.G.E.

Project: C.H.A.N.G.E. (Concepts of Handicaps and Attitudes Need Guidance and Education) is a Title IV C, Innovative ESEA Grant. The philosophy of the program is handicapped children and adults have the right to be accepted as worthwhile individuals by their non-handicapped peers and non-handicapped children and adults have the responsibility to objectively accept handicapped people.

As we are an adopter program, Project C.H.A.N.G.E. has requested control groups (for statistical purposes) in our own district.

________________________________ have been selected to be the target group.

Control sites for the program are: ____________________________________.

The Experimental Staff schedule is: Pretest - Teacher Training Program - Posttest - Instruction of students - 2nd Posttest.

The Control Staff schedule is: Pretest - No intervention - Posttest - No intervention - 2nd Posttest.

The Teacher Training Program for the kindergarten through eighth grade Experimental Staff will be offered during the school year. Further bulletins on this training program will be sent at a later date.

Our Project Staff consists of ________________________________ ____________________________. This year our Project Staff will be involved in the workshops, the implementation of the student program and collecting the statistical data needed by the State to verify the overall program effectiveness with the students.

Sample
Form #1

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 2 - FORM 2 DISTRIBUTION: Project Staff

This form was designed to delegate the sessions of the Teacher Training Program to the project staff. Each member is to be responsible for one or more sessions. The staff member must decide whether or not they want a guest speaker and if they choose to incorporate audio-visual materials.

A sample form which has all the appropriate information has been completed for referral purposes. In order to complete this form the following must be determined:

1. Format of training program

   Format 1 - designated staff reading scripts with guest speakers.
   Format 2 - video cassettes
   Format 3 - audio cassettes

2. Location of the Training Program

3. Time

4. Days of the week

5. Delegation of session to Staff Members

6. Equipment needs - hardware

7. Materials - soft ware

and 8. guest speakers - if one is desired for a particular session

After the above information has been determined a roughed out schedule can be prepared for the staff. This form will be revised several times before the training program as desired guest speakers may not be able to attend.

USE FOR FORMATS: 1, 2, 3

For formats 2 and 3, mandatory information is the dates and necessary equipment. All other items are optional but the scheduling of additional audiovisual material and guest speakers would be very beneficial for the teachers.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM - 1981 Spring
TUES. & THURS. - 8 SESSIONS - 2 HRS.

DATE/DAY	TOPIC(s)	EQUIPMENT	MATERIAL	GUEST SPEAKER	STAFF
April 9, 1981 (Thurs) Session 1	Introduction Blindness Physical Handicaps	Overhead projector Slide projector Screen Podium Tape recorder	Overheads Slides on Project CHANGE & Dennison's Slide	P.H. Mr. Dennison	S. Smith K. Delaney Galzin
April 14, 1981 (Tues.) Session 2	Diabetes	Overhead projector Screen Video Equipment	Overheads "Zarrish Video tape"		Galzin
April 28, 1981 (Tues.) Session 3	Mental Retardation Learning Disabilities	Overhead projector Screen	Overheads		Balter Balter
April 30, 1981 (Thurs) Session 4	Speech Impairments Deafness	Overhead projector Screen	Overheads	(deafness) Pat Cunneen	Smith Delaney
May 5, 1981 (Tues.) Session 5	Epilepsy	Movie projector Screen Podium	Film: Images	Mr. Ramsler	Galzin
May 7, 1981 (Thurs) Session 6	Behavioral Disorders	Overhead projector Screen	Overheads	Mr. Hamilton	Honkisz
May 12, 1981 (Tues.) Session 7	Rehabilitation Service and Health Careers	Slide projector Screen	Pfrommer's Slides	M. Pfrommer and K. Kozale	Harper
May 14, 1981 (Thurs) Session 8	Presentation of Curriculum (K-8)	Overhead projector Screen	Overheads		Primary - Harper 4 - Foulkes 5 - Delaney 6 - Galzin 7 - Balter 8 - Honkisz

ample Form
#2

Y

BUILDING: ____________________

TIME: ____________________

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM - 1981 Spring

DATE/DAY	TOPICS	EQUIPMENT	MATERIAL	GUEST SPEAKER	STAFF
Session #1	Introduction Blindness Physical Handicaps				
Session #2	Diabetes				
Session #3	Mental Retardation Learning Disabilities				
Session #4	Speech Impairments Deafness				
Session #5	Epilepsy				
Session #6	Behavioral Disorders				
Session #7	Rehabilitation Service and Health Careers				
Session #8	Presentation of Curriculum (K-8)				Entire Staff

Sample Form #2

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 3 - FORM 3 DISTRIBUTION: Staff

The Resource File is now used in procuring guest speakers for the Teacher Training Program. The Resource File is in alphabetical order by disability, speakers and agencies. It contains the names, phone numbers and addressess of speakers and agencies. The speakers listed are those available in the metropolitan Chicao area. The agencies information spans the United States.

The individuals and agencies which are listed in the Resource file have been screened and many have provided speakers for the teachers and students in the Project C.H.A.N.G.E. Producer program.

When using the Resource File to contact speakers it is advisable to keep a telephone log. Form #3 is a sample of indicating the type of recording which can be done. This log is a useful tool in maintaining a record of those individuals who have been contacted. It also serves as a reminder of pertinent information on recontacting and/or rescheduling the speaker. Information obtained and recorded in the telephone log can help update the Resource File.

USE FOR FORMATS: 1, optional 2 and 3

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

TELEPHONE LOG

DATE	PERSON CALLED	RESULTS
6-11	Wanda Lhotak	She consented to speak to K-3 children. I'll be calling back with specifics A.B.
6-16	M. Pfrommer	Agreed to persent at teacher workshop 5/12 bringing associate Ken Kozole - need to send confirmation. A.B.
6-18	Doug Hamilton	Consented to speak at workshop. Checking to see if he can handle 7 & 8 graders I'm sending confirmation letters.

Sample Form #3

Y

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

TELEPHONE LOG

DATE	PERSON CALLED	RESULTS

Sample Form
#3

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 4 - FORM 4, 4a DISTRIBUTION: Guest Speakers

When a guest speaker has agreed to participate in the Teacher Training Program a follow-up letter is to be sent. Form #4 is a sample letter. Along with the letter, a map which indicates several alternate routes to the building site should be sent to the speaker. Form #4a is a sample of the map used by the producer district.

It will be necessary to compose a letter on the district letterhead and devise a map indicating the appropriate building sites. Each speaker should receive a letter and a map as soon as possible after the initial contact.

USE FOR FORMATS: 1, optional 2 and 3

Project C.H.A.N.G.E.

Title IV C ESEA

Concepts of Handicaps and Attitudes Need Guidance and Education

DONALD W. MARTIN, Director
SHERRY SMITH, Coordinator
ROBERT L. OLCESE, Superintendent
DR. DONALD R. JOHNSON,
Assistant Superintendent and Business Manager

Dear ____________________:

This is a confirmation of your speaking engagement at ____________________ ____________________ School on ____________________. Our schedule shows the following information:

Time: ____________________

Topic: ____________________

Level: ____________________ No. of Rooms: ____________________

Building Schedules:

Building: ____________________	Building: ____________________
1. ____________________	1. ____________________
2. ____________________	2. ____________________
3. ____________________	3. ____________________
4. ____________________	4. ____________________

If any revision is necessary, please call the Project C.H.A.N.G.E. office (599-2263) with notification. A map with the location of the building and the phone number is enclosed. We are looking forward to your visit.

Yours truly,

Project Staff

Sample Form
#4

Project C.H.A.N.G.E. • Harnew School • 9100 South Austin, Oak Lawn, Illinois 60453 • (312) 599-2263

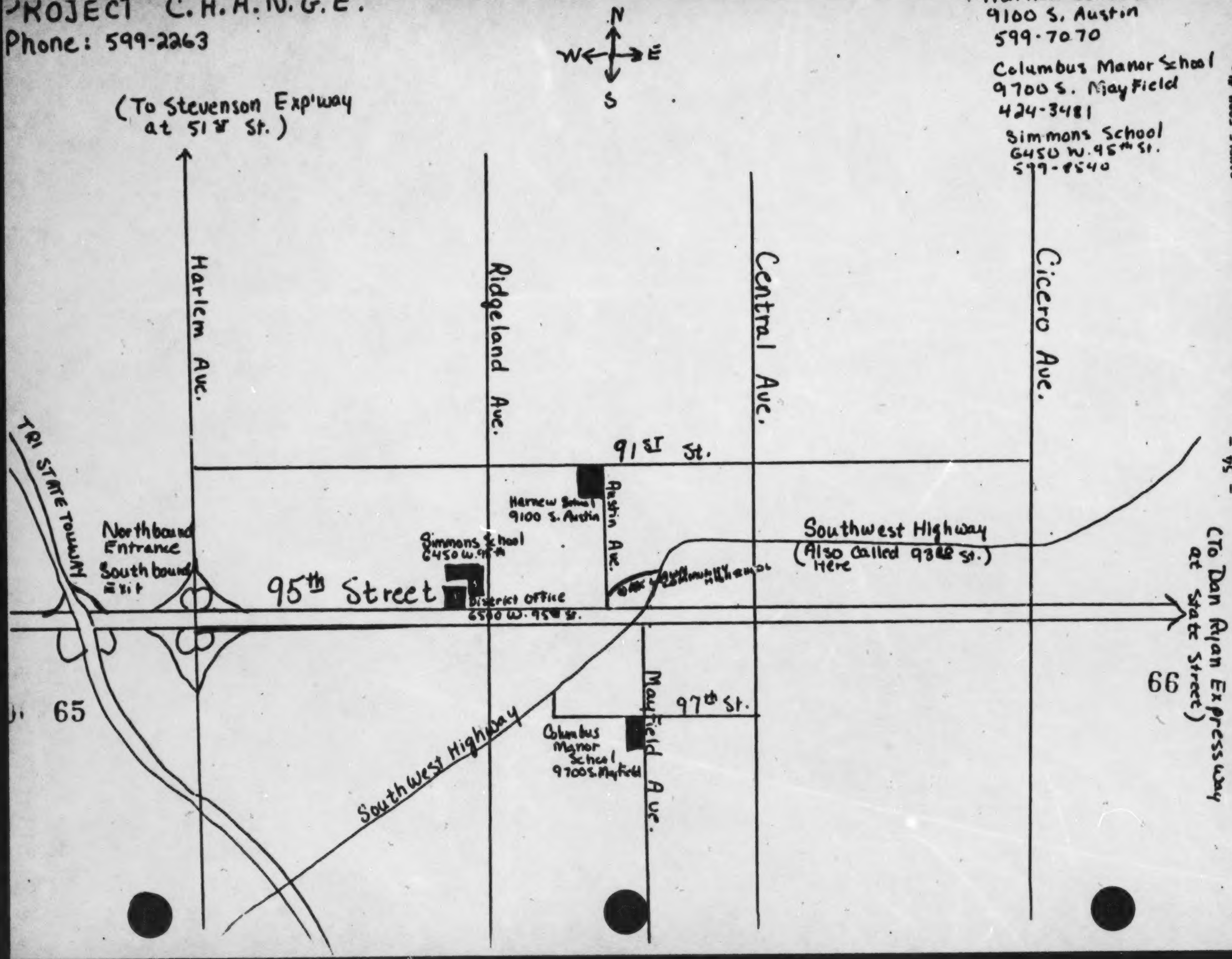
PROJECT C.H.A.N.G.E.
Phone: 599-2263

Harnew School
9100 S. Austin
599-7070

Columbus Manor School
9700 S. MayField
424-3481

Simmons School
6450 W. 95th St.
599-8540

SAMPLE FORM #a


N
W
E
S
(To Stevenson Exp'way at 51st St.)
Harlem Ave.
Ridgeland Ave.
Central Ave.
Cicero Ave.
91st St.
Harnew School 9100 S. Austin
Austin Ave.
Simmons School 6450 W. 95th
District Office 6500 W. 95th St.
Oak Lawn Community High School
Northbound Entrance
Southbound Exit
TRI STATE TOLLWAY
95th Street
Southwest Highway
(Also called 98th St.) Here
(To Dan Ryan Expressway at State Street)
97th St.
Columbus Manor School 9700 S. Mayfield
Mayfield Ave.
South West Highway
65
66

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 5 - FORM 5 DISTRIBUTION: Staff

The Program Speakers list is used to record all information regarding the scheduling of speakers. It is advisable to record the topic, the audience (training program or grade), the day/date, the building the speaker is scheduled for, speakers name, the date called, the date the letter was sent, the date of the follow-up call, transportation needs (if any), a fee, equipment needs (if any) and the date that the thank you letter was sent.

This informational form should remain with the individual who is contacting speakers as an additional quick frame of reference.

USE FOR FORMATS: 1, optional 2 and 3

Y

PROJECT: C.H.A.N.G.E. Sample Form #5

				PROGRAM SPEAKERS							
TOPIC	GRADES	SPEAKING DAY/DATE	BLDG.	SPEAKER	DATE CALLED	LETTER SENT	FOLLOWUP CALL	TRANSP. NEEDS	FEE	EQUIP. NEEDS	THANK YOU

STEP 6 - FORM 6, 6a DISTRIBUTION: Staff and Teachers

Form #6 is a general information form which is distributed to the experimental teachers or all teachers who are eligible to attend the Teacher Training Program. It contains information pertinent to the program site, time and days. A returnable portion is available on the form so the audience for the Teacher Training Program can register prior to the first session.

This prior registration will help the staff determine the number of handout materials which must be duplicated. The responses from the teachers can be recorded on form #6a, so an accurate count of participants can be determined prior to the program. Form 6a the returnable slip's from form #6 is to remain with the coordinator.

USE FOR FORMATS: 1, 2, 3.

Y

STAFF:

WHO:
FROM:

WHAT:

WHERE:
WHEN:

On ___________________________, the Title IV C ESEA Project: C.H.A.N.G.E. Student Program begins at ____Schools. As you know, all the Experimental rooms at these buildings will devote a minimum of one period per week to the activities of Project: C.H.A.N.G.E.

Some of the topics to be covered at the Teacher Training Program are: blindness, epilepsy, diabetes, physical handicaps and rehabilitation. These topics will be presented by the Project Staff and handicapped speakers.

Movies, filmstrip kits and audio-visual equipment to be involved in the program will also be covered.

RETURN THIS PORTION BY ____________________________ TO: ____________________________

____________________ I WILL ATTEND THE WORKSHOP

____________________ I WILL NOT ATTEND THE WORKSHOP

NAME: ____

SCHOOL: ____

Sample
Form # 6

Y

PROJECT: C.H.A.N.G.E.

TEACHERS WHO RECEIVED TRAINING PROGRAM BULLETIN

EXPERIMENTAL TEACHERS	GRADE-BLDG.	RESP.	NO.RESP.	ATTEND	NOT ATTEND	RE-CONTACTED	

72

Sample
Form
6a

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 7 - FORM 7 DISTRIBUTION: Staff and Teachers

The Teacher Training Program Reminder is to be distributed to all potential training program participants several days before the first session. This form reminds participants of the program dates, location, time and room.

USE FOR FORMATS: 1, 2, 3

Y

PROJECT

TEACHER TRAINING PROGRAM REMINDER!!!!!!!

CONCEPTS OF HANDICAPS AND ATTITUDES NEED GUIDANCE AND EDUCATION
CHANGE

DATE:

LOCATION:

TIME:

ROOM:

A TITLE IV C PROGRAM - STATE OF ILLINOIS

Sample
Form #7

PROJECT: C.H.A.N.G.E.
TITLE IV C -, ESEA

STEP 8 - FORM 8, 8a DISTRIBUTION: Staff

These forms are records of attendance for the Teacher Training Program. Form #8 is to record the attendance of the experimental teachers, while form #8a focuses on the attendance of the designate training staff.

On the Experimental Teachers form it is necessary to record the grade they teach, their "home" building and to check off whether or not they signed a publicity release for the program.

Under each session number there are two boxes, the first box is checked when a teacher takes her project book containing the handouts (prepared by the staff) at the beginning of the session. The second box is checked when the teacher returns the project book at the conclusion of the session. The project books should be passed out at the beginning of the session and collected at the end of the session. This procedure will eliminate the loss of books on the part of participants and eliminate additional duplications by the staff. A time and cost factor problem can be eliminated by the "In" and "Out" method. At the last session teachers are allowed to keep their project book.

USE FOR FORMATS: 1, 2, 3

PROJECT: .H.A.N.G.E.
TEACHER TRAINING WORKSHOP
SESSIONS FOR SPEAKER PRESENTATION
Dates:

EXPERIMENTAL TEACHERS	GRADE-BLDG.	PUBLICITY Releases Signed	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	TOTAL Sess. Attnd.

Sample Form # 8

PROJECT C.H.A.N.G.E.
TEACHER TRAINING WORKSHOP

SESSIONS FOR SPEAKER PRESENTATION

DATES:

WORKSHOP STAFF	POSITION	PUBLICITY Releases Signed	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	TOTAL Sessions Attended

Sample
Form # 8a

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 9 - FORM 9 DISTRIBUTION: Staff and Faculty

The Publicity Release form must be done in duplicate. This release form is to be signed by all staff, teachers participating in the training program and guest speakers for the training and student program.

The signed copies are to be kept in a file and monitored by the coordinator. The staff and teachers can sign their forms at the first training program session. A check off box for signed publicity releases appears on form #'s 8 and 8a.

Guest speakers can be asked to sign this form on the day they are speaking. It is only necessary to have someone sign a form if they are to be photographed, videotaped or if their voice is to be taped. The Producer program has a right to request publicity photographs from the training program to be used in dissemenation.

USE FOR FORMATS: 1, 2, 3

Y

Project: C.H.A.N.G.E.
ESEA Title IV C

This form must be done in duplicate:

I hereby give my permission to release for Project C.H.A.N.G.E. ESEA Title IV C, to use my picture and/or voice by itself or in a video-tape or slide-tape presentation for publicity purposes or for use in this program.

Date________________________ Signature________________________________

Project: C.H.A.N.G.E.
ESEA Title IV C

This form must be done in duplicate:

I hereby give my permission to release for Project C.H.A.N.G.E. ESEA Title IV C, to use my picture and/or voice by itself or in a video-tape or slide-tape presentation for publicity purposes or for use in this program.

Date________________________ Signature________________________________

Sample
Form #9

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 10 - FORM 10 DISTRIBUTION: Staff and Teachers

This evaluation form is for the Teacher Training Program. It is advisable to evaluate the Program in two stages. The first time the program should be evaluated occurs after session #4. Form #10 is used for the Mid-Teacher Training Program Evaluation.

This sample will serve as a guide for the district form which the coordinator must design. Under each date list the title of the activity and the presentor. The rating scale appears in a column opposite each activity. A pace for comments is provided for each session. Tabulation of this information is valuable to the staff as it indicates areas of strength and weakness in presenting the Teacher Training Program.

For those districts using Format 2 and 3, it will be necessary to evaluate the effectiveness of the video and audio-tapes. Also, if guest speakers are present, a form of feedback from the staff will indicate whether it is desirable or not to have this guest speaker return for future workshops or to speak to the students.

USE FOR FORMATS: 1, 2, 3

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

The rating scale for specific workshop activities is:

3 - excellent
2 - good
1 - poor

Please rate each item - circle one.

October 2nd - Presentation	E	G	P
Slide Show - Handicapism	3	2	1
Blindness - K. Delaney	3	2	1
Film - Seven Minute Lesson	3	2	1
Guest Speaker - Mr. Davis	3	2	1

Comments: ______________________________

____

October 9th			
Diabetes - L. Galzin	3	2	1
Videotape - Zarrish Family: The People	3	2	1

Comments: ______________________________

____

October 16th			
Mental Retardation vs. Learning Disabilities - K. Harper	3	2	1
Filmstrip - The Mentally Retarded	3	2	1
Speech Impairments - S. Smith	3	2	1
Guest Speaker - Mr. Dybel	3	2	1

Comments: ______________________________

____

Form # 10

SAMPLE

October 23rd	E	G	P
Deafness - S. Smith	3	2	1
Filmstrip - Why Am I Different? I Am Deaf.	3	2	1
Physical Handicaps - L. Galzin	3	2	1
Guest Speaker - Mr. Dennison	3	2	1

Comments: ____

____

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

STEP 11 - FORM: 11, 11a, 11b DISTRIBUTION: Staff and Teachers

Form #11 is a final evaluation form for the Teacher Training Program. This form should be presented at session #8. Allow ten to fifteen minutes at the conclusion of the last session for teachers to evaluate the program. Form #11 contains information on the activities and presentors for the last four sessions (#5 - #8).

Two other evaluation forms are given to the teachers at the last session. These are form #11a and form #11b. Form #11a is a general evaluation of the use of time, training materials, the physical environment of the program and the meeting of individual needs. Form #11b is a seminar workshop evaluation from which is recommended by the State of Illinois as useful in evaluation. All three forms have been used several times by the Producer district and have been found to be invaluable in the area of evaluation.

USE FOR FORMATS: 1, 2, 3

Forms may need to be modified for those districts using Formats 2 and 3.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

SAMPLE
for
Speaker Presentation

The rating scale for specific Workshop activities is:

3 - excellent
2 - good
1 - poor

Please rate each item - circle one.

October 30 - Presentation	E	G	P
Emotional Problems - R. Honkisz	3	2	1
Videotape - PROVE Underway	3	2	1
Guest Speaker - Oak Lawn Family Services Representative	3	2	1

Comments:______________________________________

____

November 6th			
Epilepsy - L. Galzin	3	2	1
Film - Images	3	2	1
Guest Speaker - Tom Ramsler	3	2	1

Comments:______________________________________

____

November 13th			
Rehabilitation Services and Health Careers - I. Marmer and C. Foulkes	3	2	1
Film - The Way Back	3	2	1
Guest Speaker: Dennis Schriber	3	2	1

Comments:______________________________________

____

Form # 11

SAMPLE

November 20th	E	G	P
Curriculum Presentations			
Grade Level 4 - Harper	3	2	1
5 - Delaney	3	2	1
6 - Marmer & Foulkes	3	2	1
7 - Honkisz	3	2	1
8 - Smith	3	2	1
Guest Speaker: Glen Bluemer	3	2	1

Comments:____

____

Form # 11

Y

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
INSERVICE TRAINING EVALUATION SHEET

Date____________________________________

1. Training is planned so that adequate time is allotted for all activities. Yes____ No____
2. The physical training environment encouraged participant reaction. Yes____ No____
3. Materials used in training are the most up-to-date possible. Yes____ No____
4. Training sessions are well-planned. Yes____ No____
5. Activities during the training sessions are directly related to tasks and activities performed on the job. Yes____ No____
6. Activities are structured so that participants can take an active role rather than a passive one. Yes____ No____
7. Training materials are interesting. Yes____ No____
8. Project Staff was competent and knowledgeable in their areas. Yes____ No____
9. Do you feel your needs have been met? Yes____ No____
10. Training results in participants knowledge of handicaps. Yes____ No____
11. Do you think you can upgrade your health program as a result of this training experience? Yes____ No____
12. Handout materials are applicable for additional knowledge and classroom use. Yes____ No____

Form # 11a

Y

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

SEMINAR - WORKSHOP EVALUATION

Would you please mark (X) in the box which best expresses your opinion about this program. You may or may not wish to sign this form.

	Excellent	Good	Fair	Poor
1. Rate this program for holding your interest				
2. How practical was the program?				
3. How adequate was the time allotment for the program?				
4. What was your opinion of subject content?				
5. How well were the theoretical aspects treated in the program?				
6. How well did the program emphasize key points?				
7. How would you rate your personal growth from this program?				
8, How would you rate the facilities?				
9. How would you rate the helpfulness of the staff?				

Sample Form
#11b

PROJECT
CONCEPTS OF HANDICAPS AND ATTITUDES NEED GUIDANCE AND EDUCATION
CHANGE

PART II

AUDIOVISUAL MATERIALS FOR THE TEACHER TRAINING PROGRAM

UTILIZATION OF OVERHEADS

This section is designed to provide those implementating the scripts with specific overheads to accompany the lectures. Districts using format 1 will need to make overhead transparencies of the following pages in order to present their lecture.

Each overhead is labelled in the lower right hand corner with the title of the lecture it accompanies. Overheads should be prepared prior to the presentation so lecturers may practice in advance.

PROJECT: C.H.A.N.G.E.

DEVELOPMENT

PROJECT C.H.A.N.G.E. staff developed: 1) a Teacher Training Program 2) a sequential task analyzed curriculum for each level of the program 3) a teacher's manual for each level and 4) assessment instruments.

↓

TRAINING

TEACHER TRAINING PROGRAM

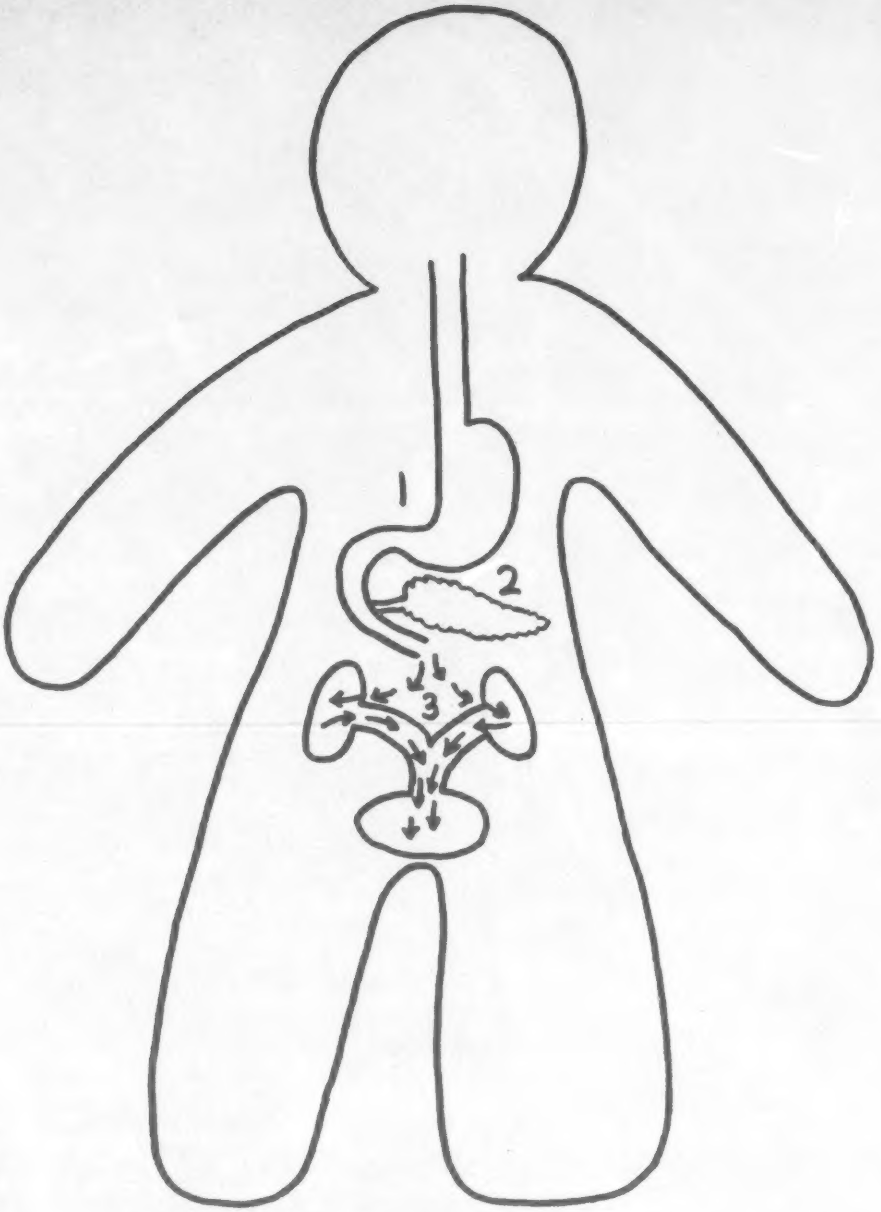
Staff will learn about: overall project plan, causes and problems of handicaps, and content material for their respective grade levels.

↓

IMPLEMENTATION

K-3 Students	4th Grade	5th Grade	6th Grade	7th Grade	8th Grade
Students will learn about: the senses & problems of the handicapped.	Students will learn about: the eye and circulatory system, blindness and diabetes.	Students will learn about: the ear & oral mechanisms, deafness and speech impairments.	Students will learn about: the nervous system & basic anatomy, epilepsy, & physical handicaps.	Students will learn about: the nervous system, mental retardation, learning disabilities, and emotional.	Students will learn about: rehabilitation and careers.

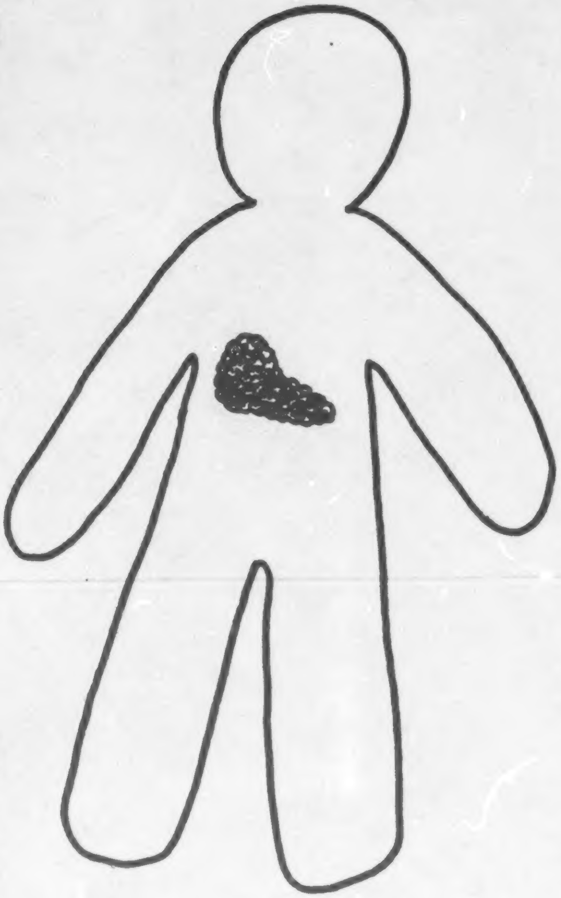
Cascade #1

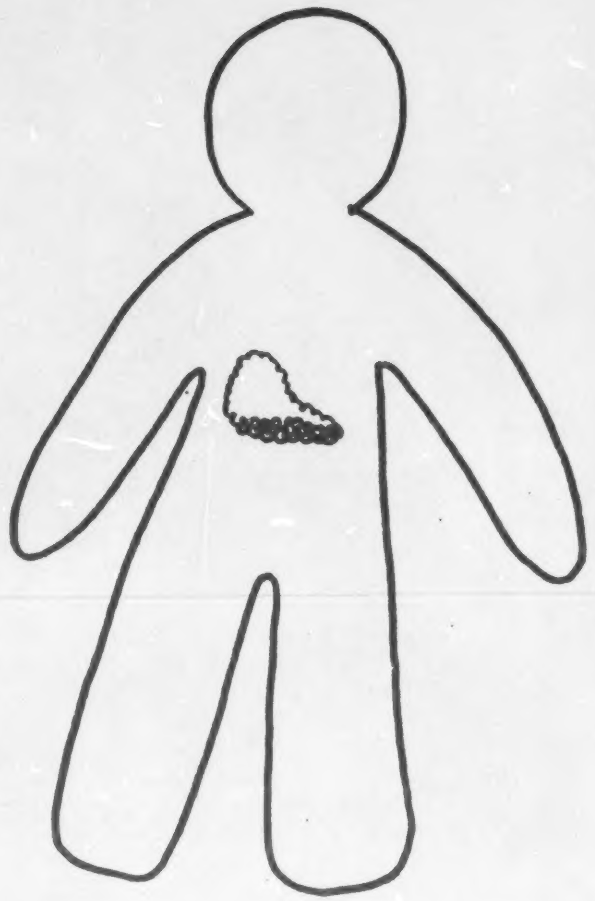


METABOLISM IN DIABETES

INGESTED FOODSTUFF IS BROKEN DOWN INTO FATS, PROTEINS, AND CARBOHYDRATES IN THE STOMACH (1). THE CARBOHYDRATES, HOWEVER, ARE NOT CORRECTLY ABSORBED BECAUSE THE PANCREAS (2) DOESN'T SECRETE ENOUGH INSULIN TO BURN UP CARBOHYDRATES AND STORE THEM IN THE LIVER TO SUPPLY THE BODY WITH ENERGY. THEREFORE, THE SUGAR OR GLUCOSE FORM OF CARBOHYDRATE BUILDS UP IN THE BLOOD AND PASSES THROUGH THE KIDNEYS (3) AND INTO THE URINE.

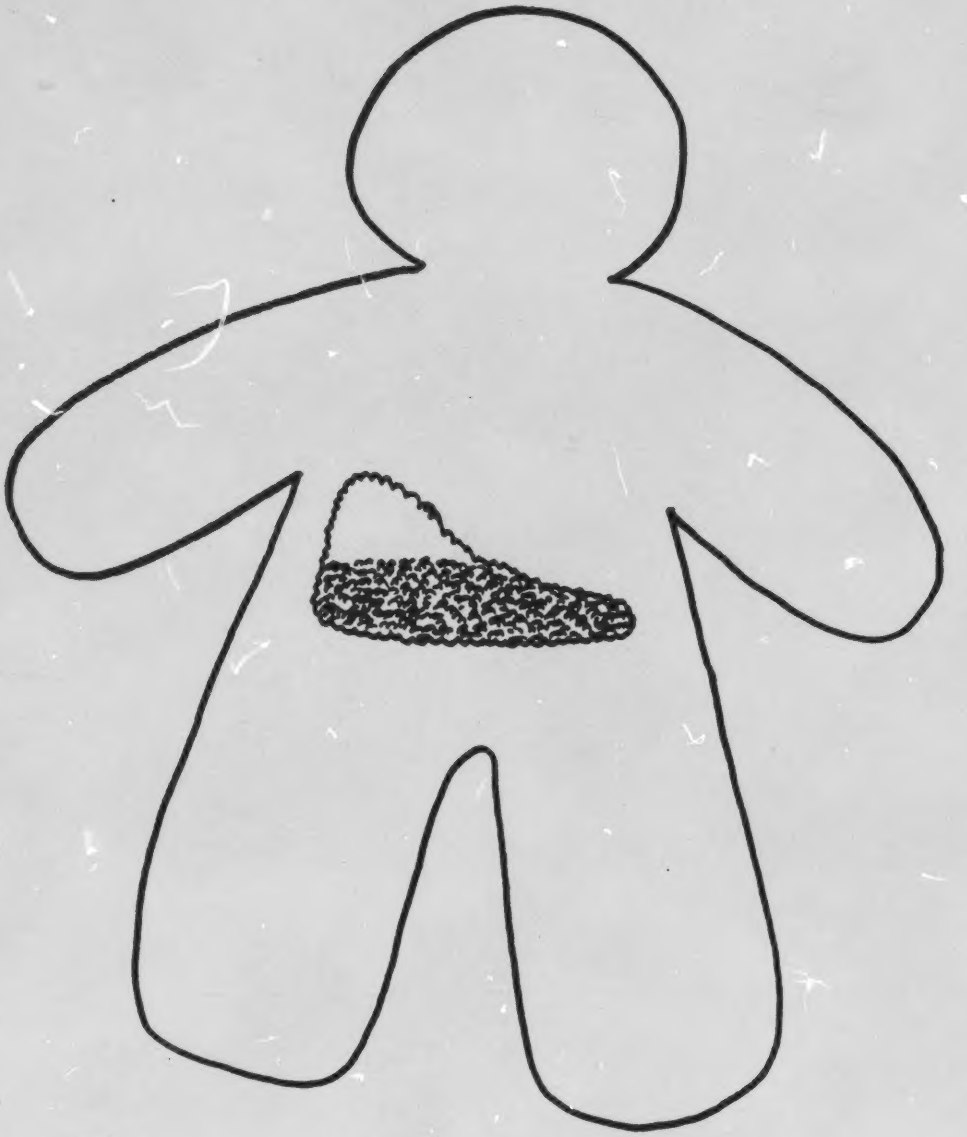
Diabetes #1





INSULIN AND THE PANCREAS

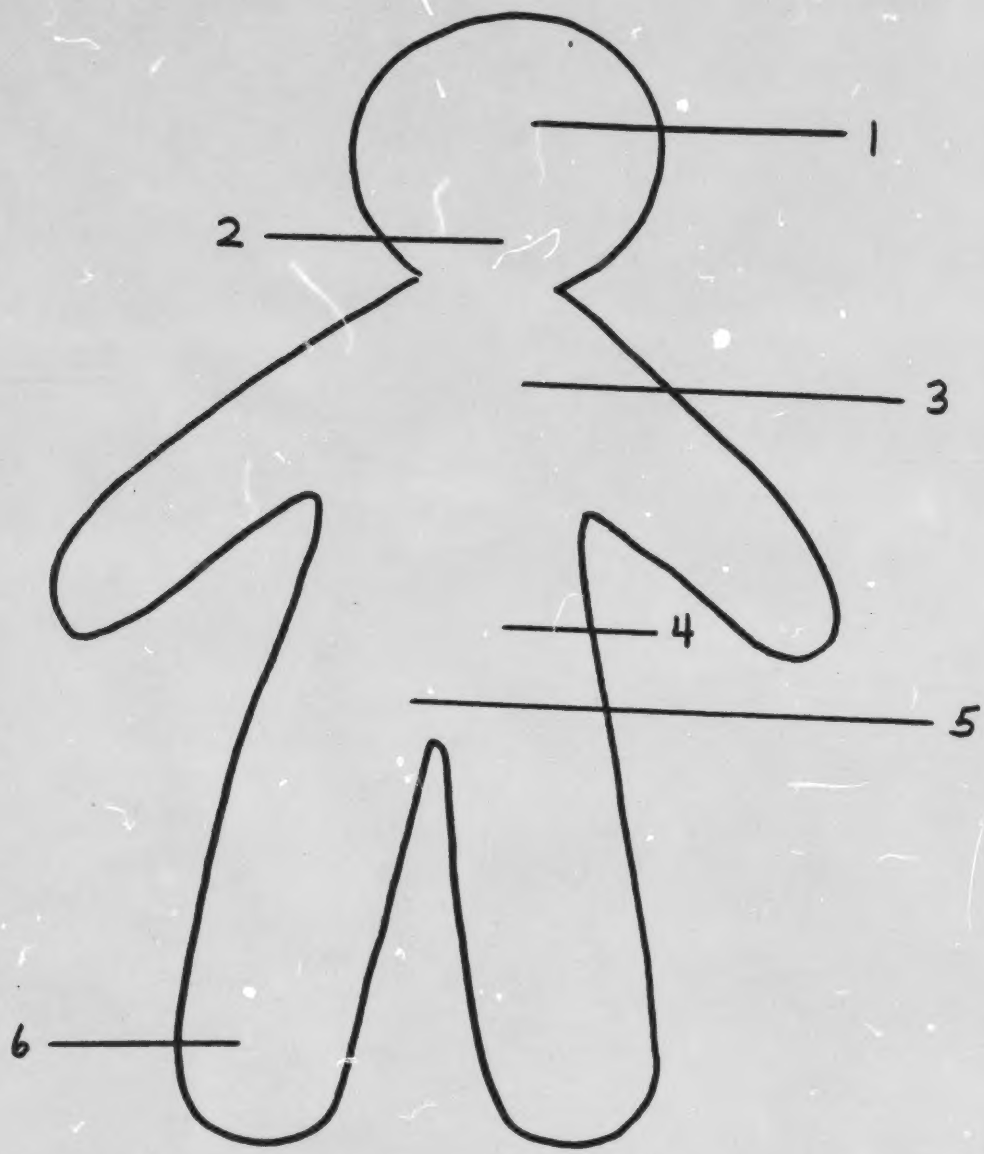
THE PANCREAS HAS AN ADEQUATE SUPPLY OF INSULIN IN THE NORMAL INDIVIDUAL. THIS IS SHOWN BY THE DARK AREA IN FIG. 1. THE INSULIN - DEPENDENT DIABETIC (FIG. 2) HAS A PANCREAS THAT FAILS TO PRODUCE A SUFFICIENT SUPPLY OF INSULIN.



OVERWEIGHT DIABETES

IN THE OVERWEIGHT DIABETIC THE PANCREAS PRODUCES AN ADEQUATE SUPPLY OF INSULIN BUT PART OF IT (SHADED AREA) IS INACTIVE. THIS IS THE MOST COMMON FORM OF DIABETES. IT USUALLY DOESN'T OCCUR UNTIL MIDDLE AGE AND IS MOST COMMONLY FOUND IN OVERWEIGHT WOMEN.

Diabetes #3



COMPLICATIONS OF DIABETES

DIABETES MOST COMMONLY AFFECTS THE BLOOD VESSELS IN THE EYES (1) AND THE SUPPLY OF BLOOD TO THE GUMS RESULTING IN DENTAL PROBLEMS (2). OTHER COMPLICATIONS CAUSED BY DIABETES INCLUDE HEART DISEASE (3), KIDNEY DISEASE (4) GASTROINTESTINAL DISORDERS SUCH AS DIARRHEA AND CRAMPS (5) AND IMPAIRED CIRCULATION THROUGHOUT THE BODY ESPECIALLY IN THE FEET (6).

Diabetes #4

DIABETIC REACTIONS

	INSULIN REACTION	ACIDOSIS/DIABETIC COMA
CAUSE	BLOOD SUGAR IS TOO LOW	BODY INSULIN IS TOO LOW
SIGNS	SUDDEN ONSET	GRADUAL ONSET
	SKIN IS PALE, MOIST	SKIN IS FLUSHED, DRY
	EXCITED APPEARANCE	DROWSY APPEARANCE
	NORMAL BREATH ODOR	FRUITY BREATH ORDOR
	NORMAL TO SHALLOW BREATHING	DEEP LABORED BREATHING
	MOIST TONGUE	DRY TONGUE
	HUNGER	NO HUNGER
	NO VOMITING	VOMITING
	NO THIRST	INCREASED THRIST
	NO SUGAR IN URINE	LARGE AMOUNTS OF SUGAR IN URINE
TREATMENT	EAT SUGAR OR SOME FOOD CONTAINING SUGAR	INSULIN

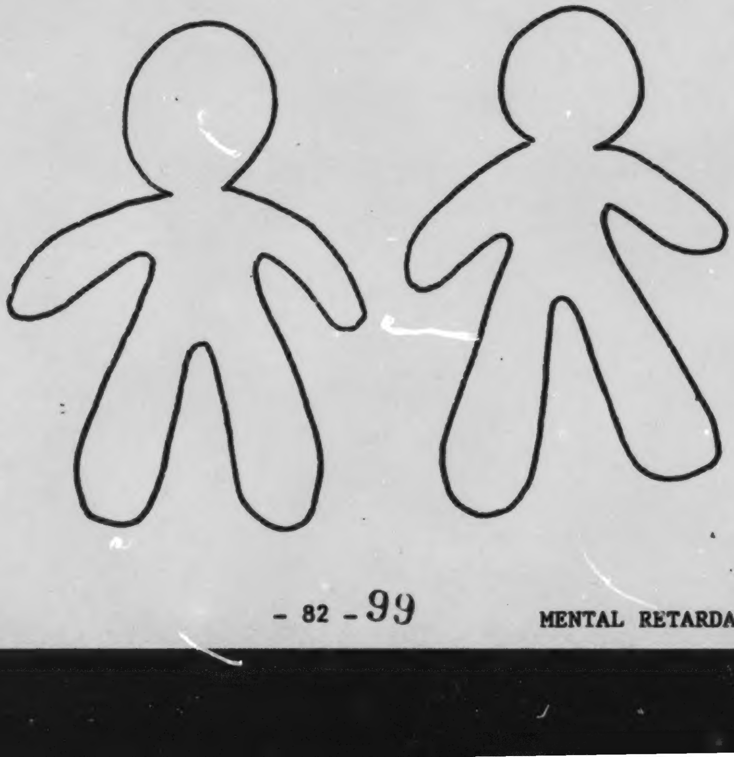
Diabetes #5

DEFINITION

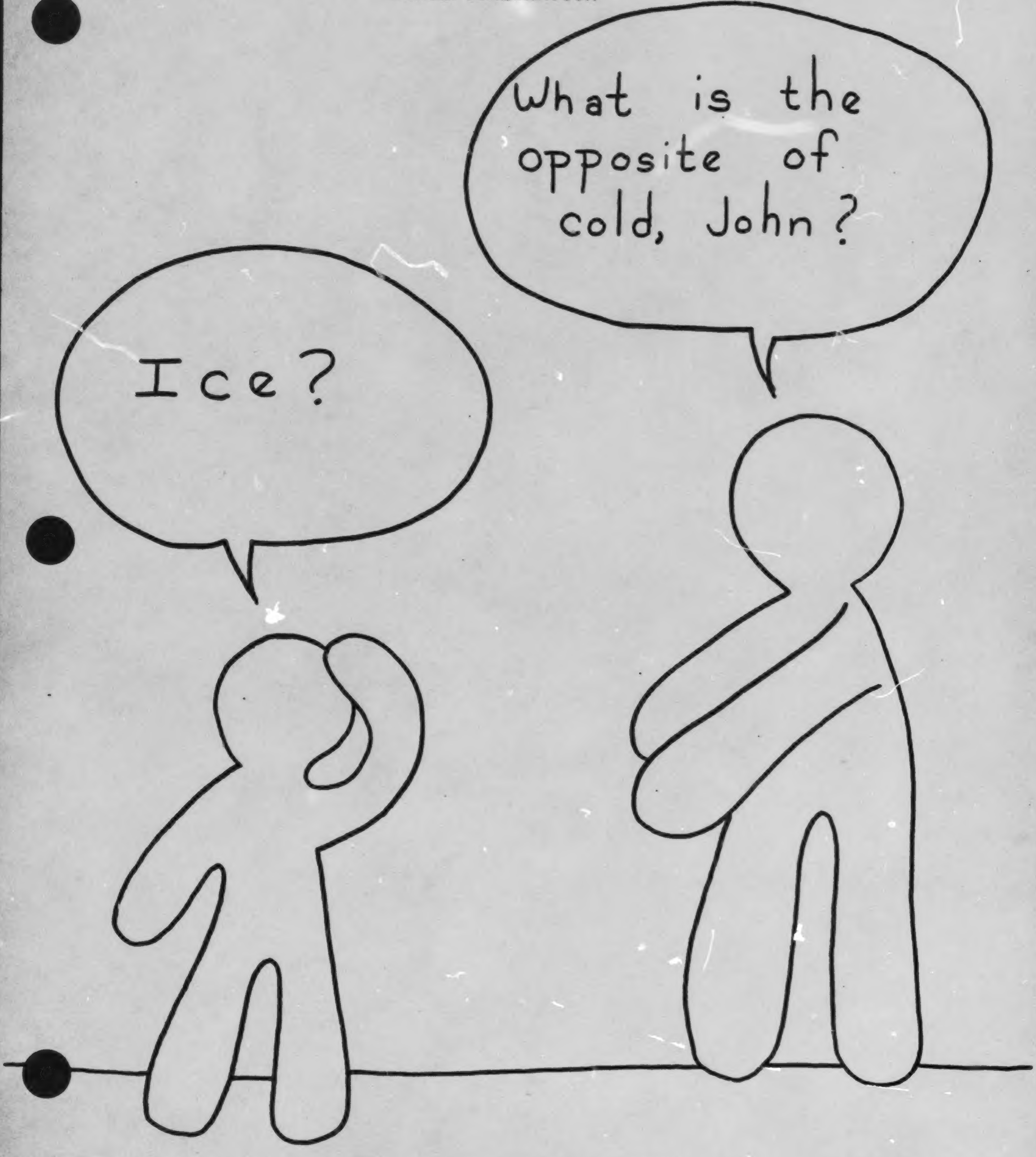
MENTAL RETARDATION IS CHARACTERIZED BY SIGNIFICANTLY SUBAVERAGE INTELLECTUAL FUNCTIONING EXISTING CONCURRENTLY WITH DEFICITS IN ADAPTIVE BEHAVIOR AND MANIFESTED DURING THE DEVELOPMENTAL PERIOD.

DIAGNOSTIC CLASSIFICATION

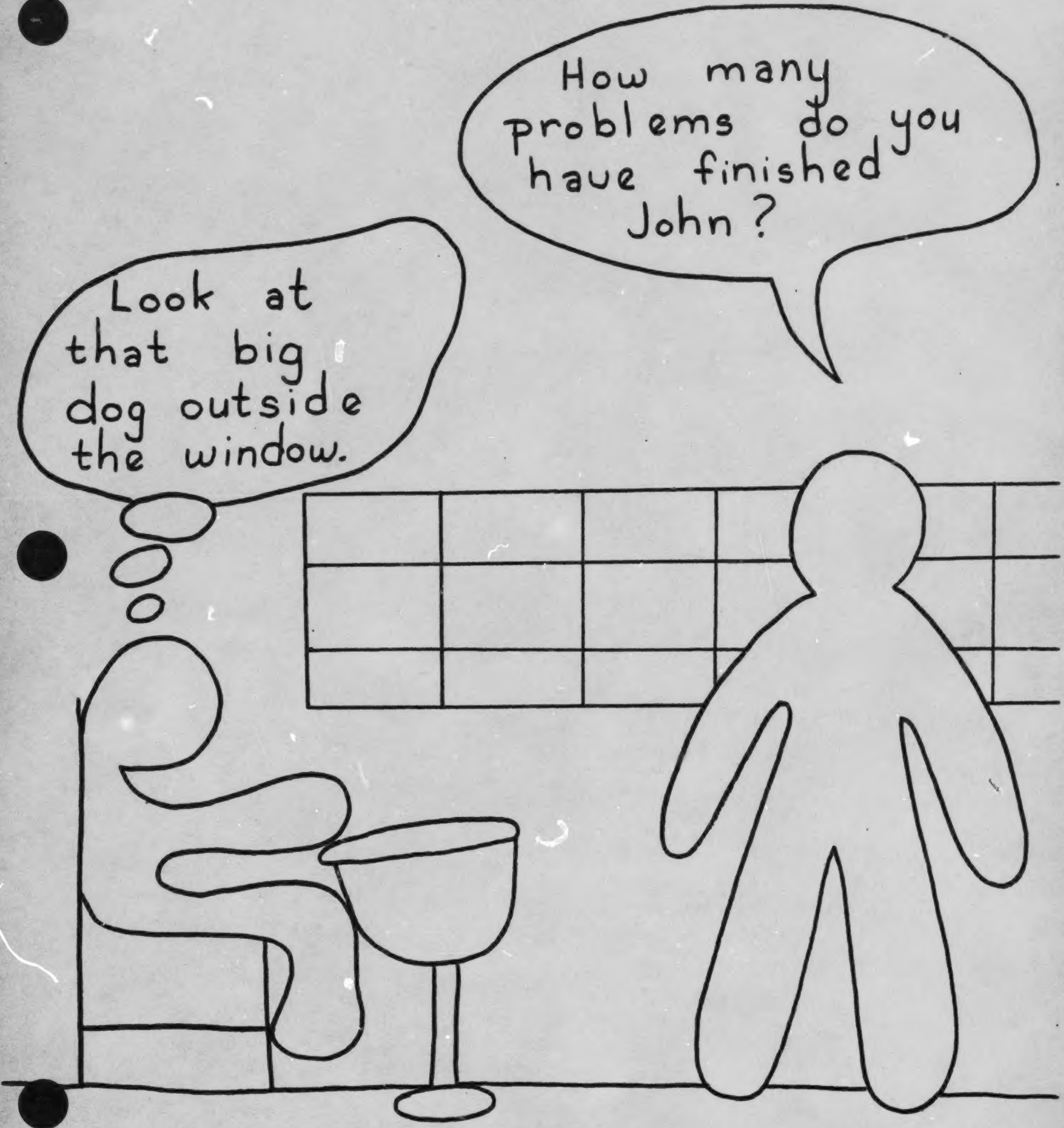
MILD MENTAL RETARDATION	I.Q.	52-67
MODERATE MENTAL RETARDATION	I.Q.	36-51
SEVERE MENTAL RETARDATION	I.Q.	20-35
PROFOUND MENTAL RETARDATION	I.Q.	UNDER 20



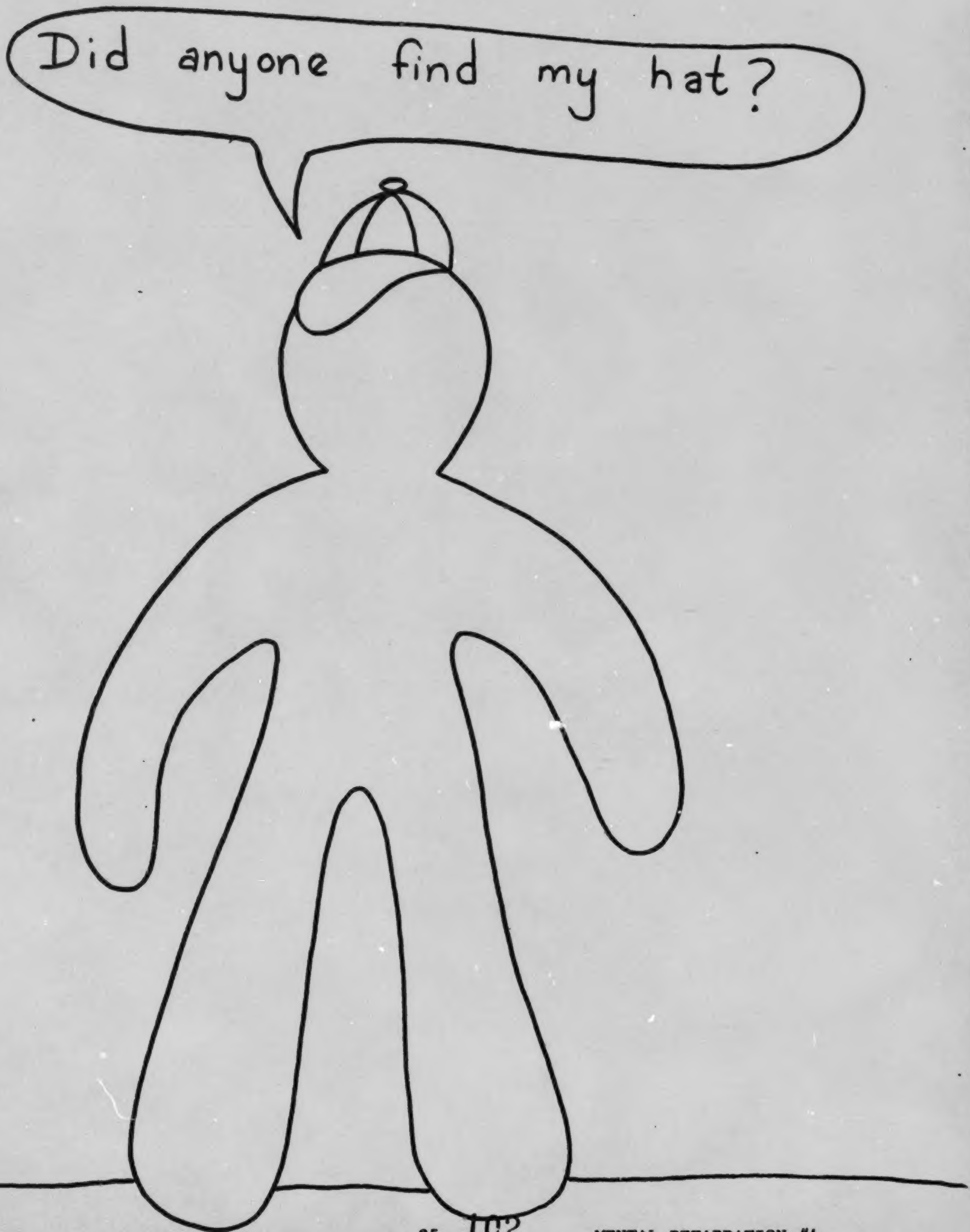
CONCEPTUALIZATION


What is the opposite of cold, John?
Ice?

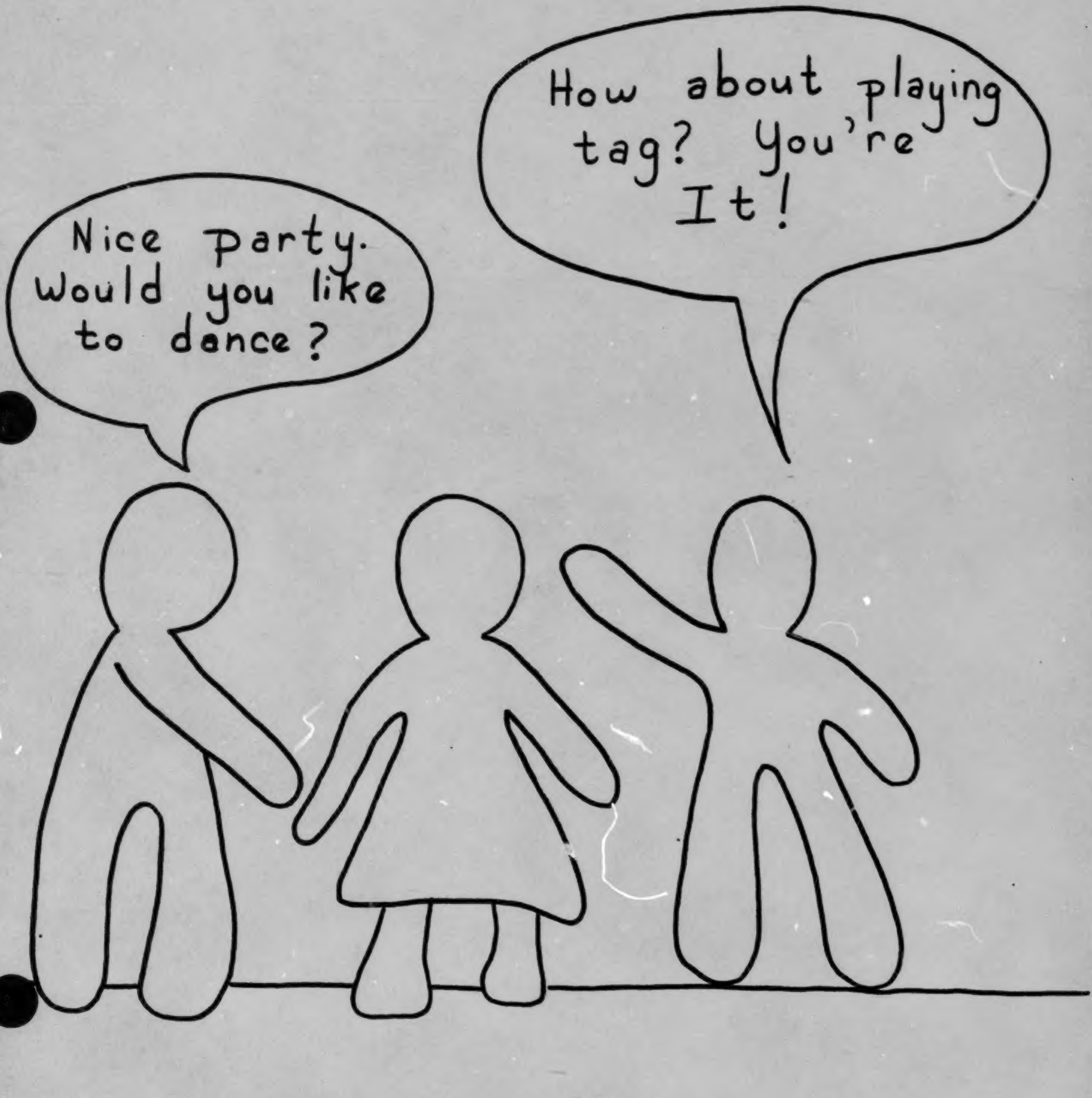
ATTENTION SPAN


How many problems do you have finished John?
Look at that big dog outside the window.

SHORT - TERM MEMORY


Did anyone find my hat?

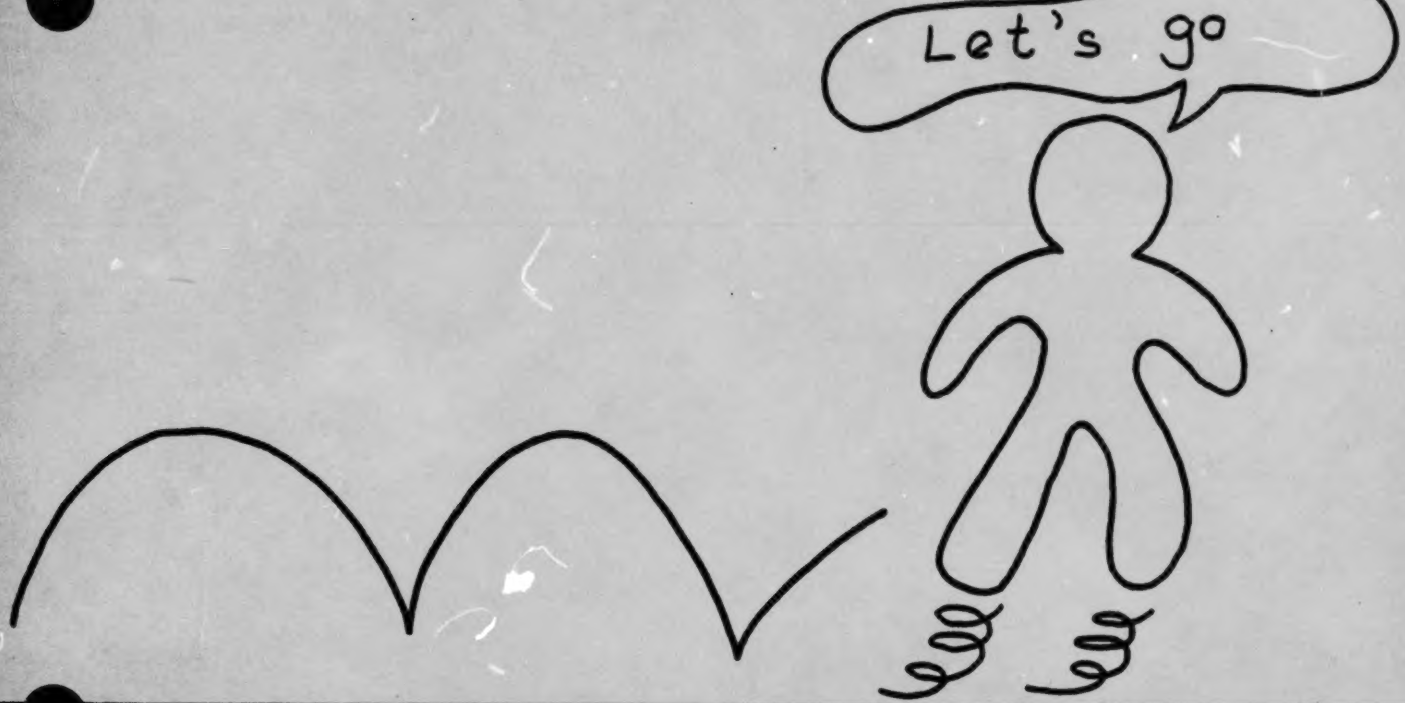
SOCIAL IMMATURITY

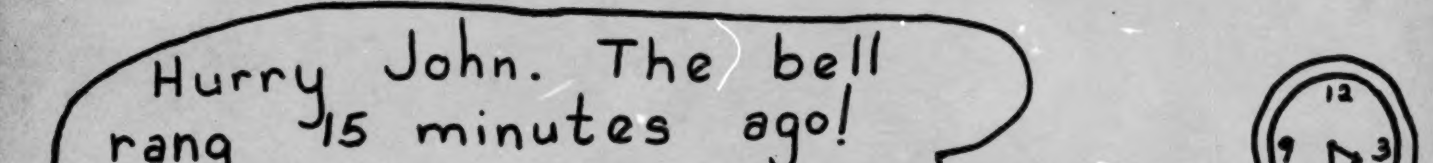

Nice party. Would you like to dance?
How about playing tag? You're It!

DEFINITION

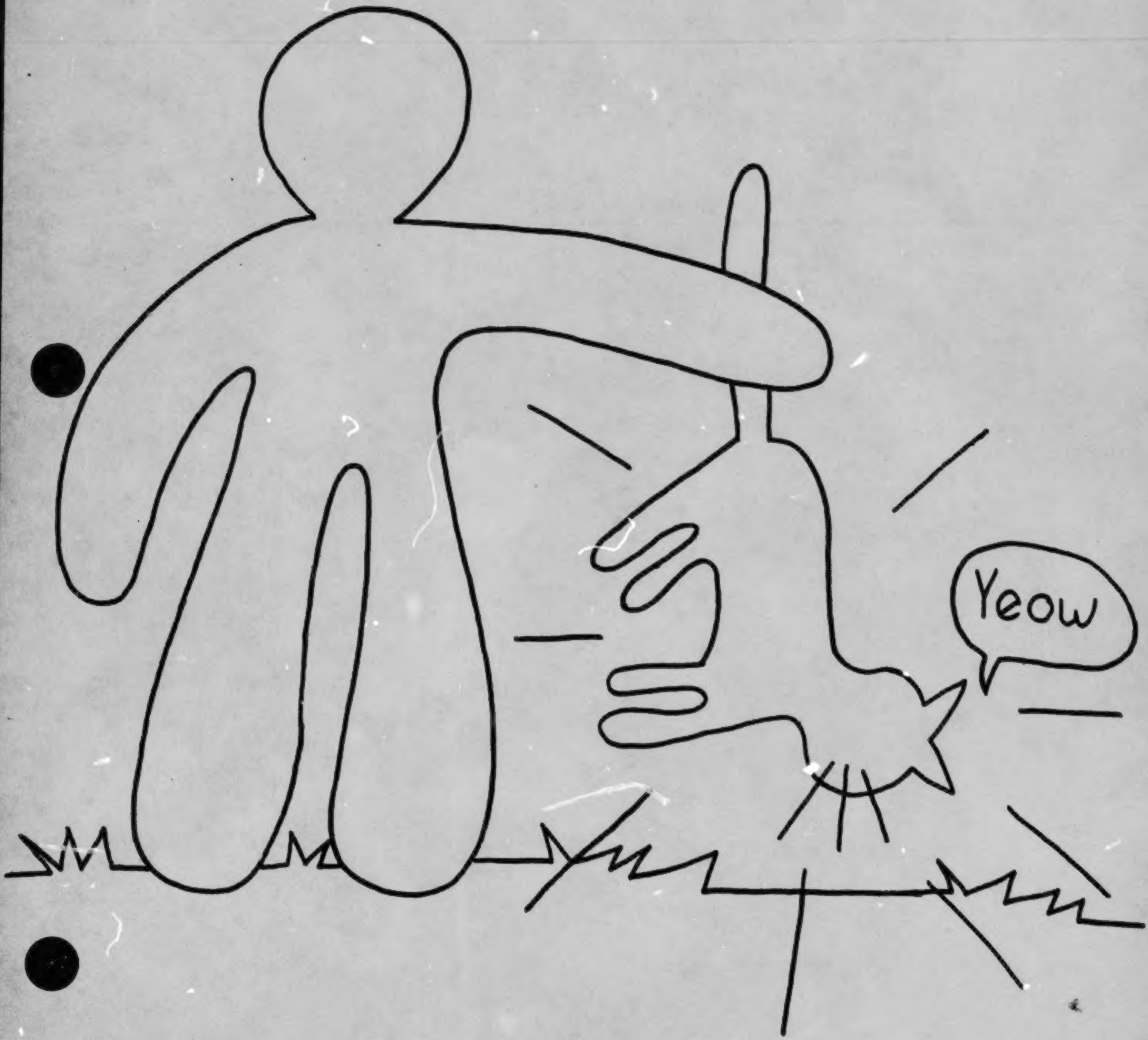
CHILDREN WITH SPECIFIC LEARNING DISABILITIES EXHIBIT A DISORDER IN ONE OR MORE OF THE BASIC PSYCHOLOGICAL PROCESSES INVOLVED IN UNDERSTANDING OR IN USING SPOKEN OR WRITTEN LANGUAGE. THESE MAY BE MANIFESTED IN DISORDERS OF LISTENING, THINKING, TALKING, READING, WRITING, SPELLING, OR ARITHMETIC. THEY INCLUDE CONDITIONS WHICH MAY HAVE BEEN REFERRED TO AS PERCEPTUAL HANDICAPS, BRAIN INJURY, MINIMAL BRAIN DYSFUNCTION, DYSLEXIA, DEVELOPMENTAL APHASIA, ETC. THEY DO NOT INCLUDE LEARNING PROBLEMS WHICH ARE DUE PRIMARILY TO VISUAL, HEARING, OR MOTOR HANDICAPS, TO MENTAL RETARDATION, EMOTIONAL DISTURBANCE OR TO ENVIRONMENTAL DEPRIVATION.

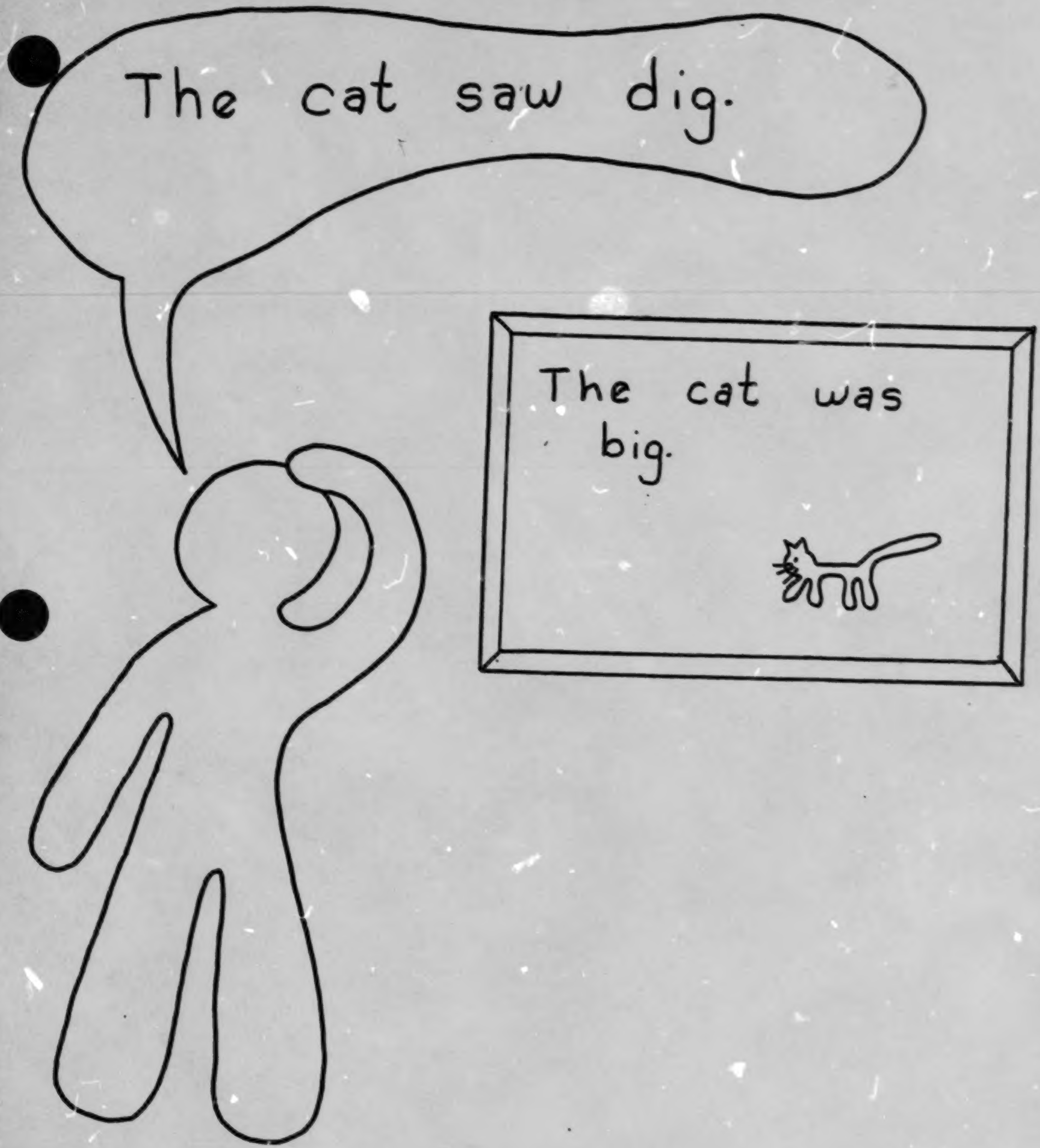
HYPERACTIVITY/HYPOACTIVITY



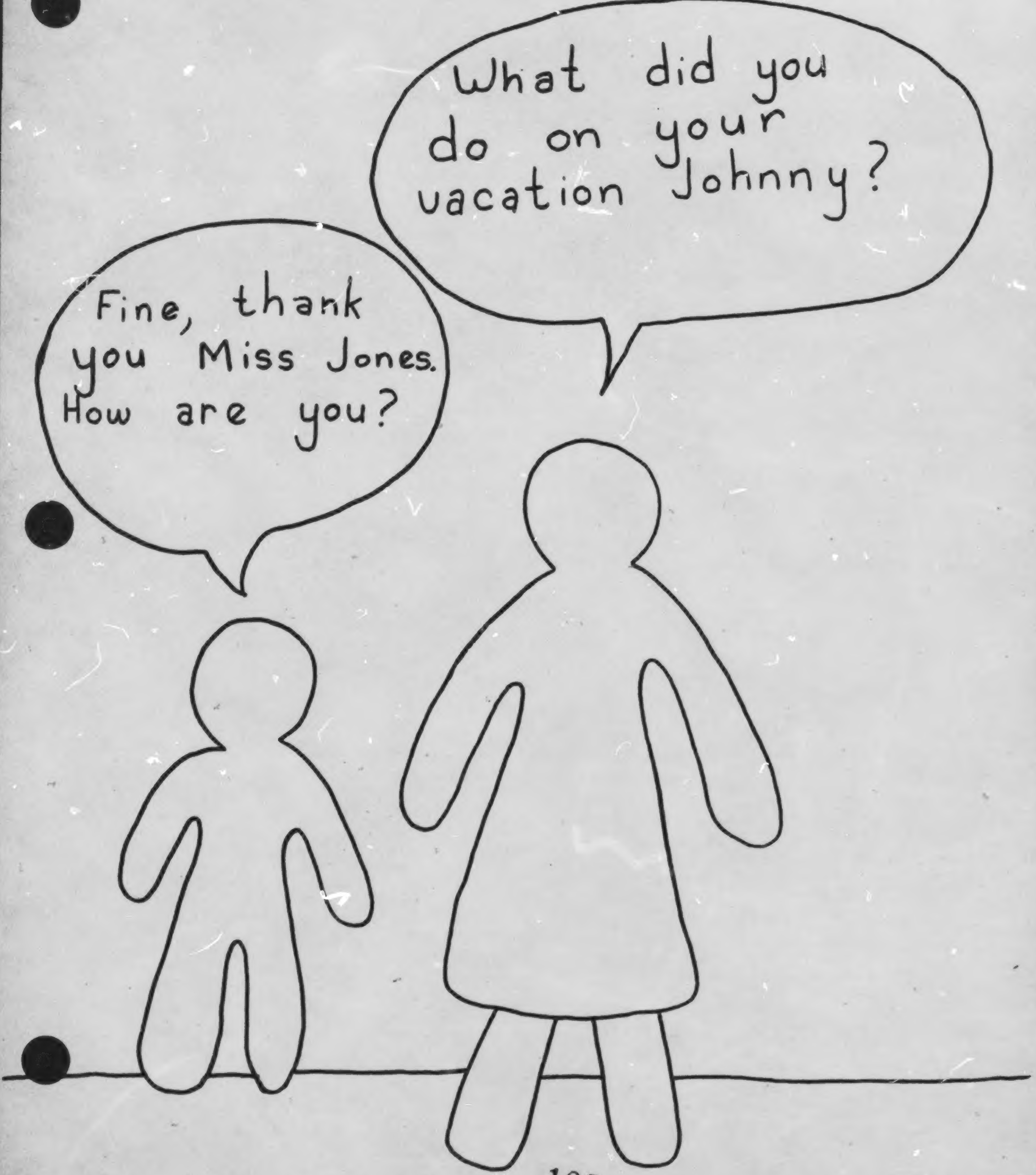

Hurry John. The bell rang 15 minutes ago!
12
9
3
6

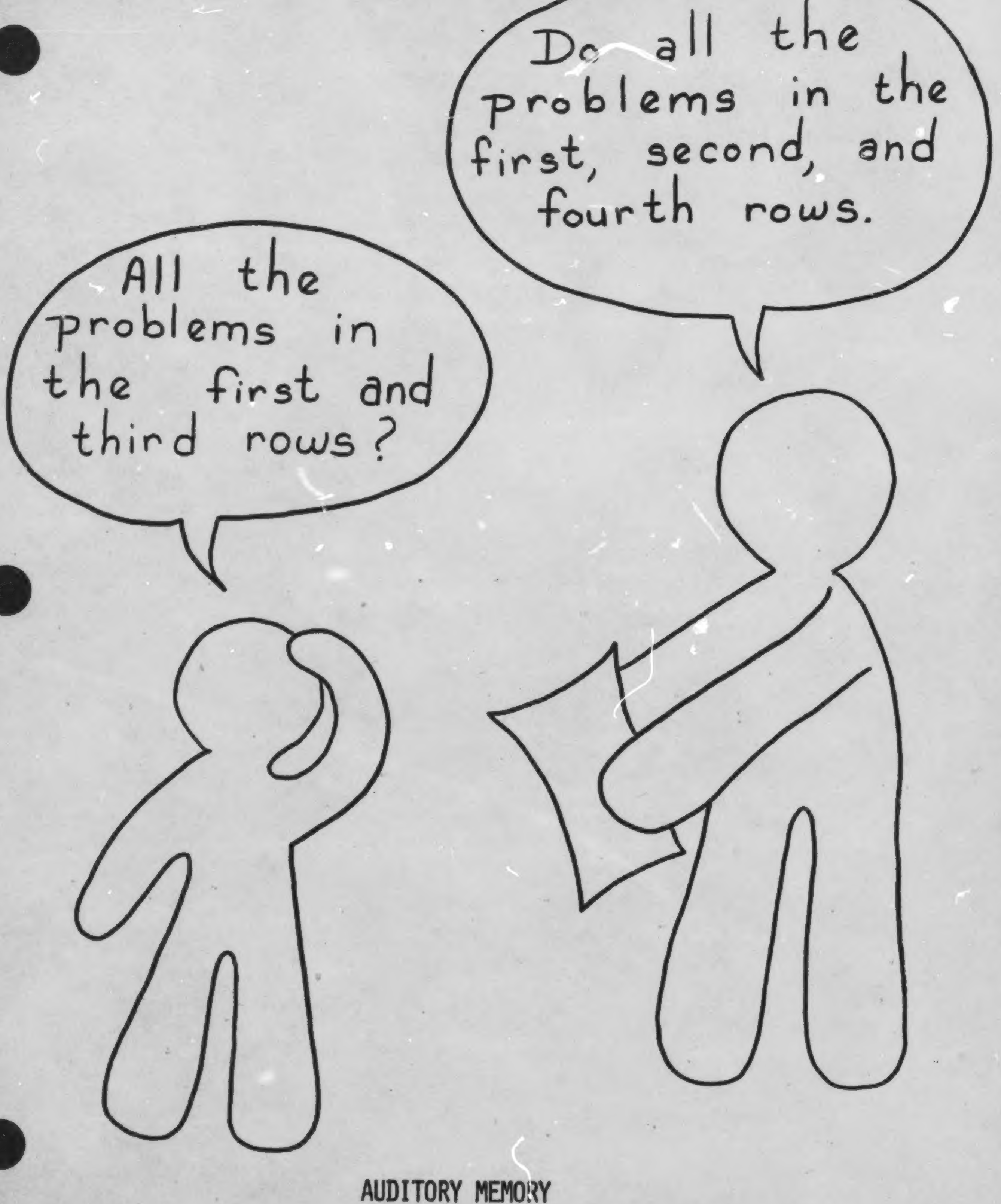
IMPULSIVENESS




The cat saw dig.
The cat was big.

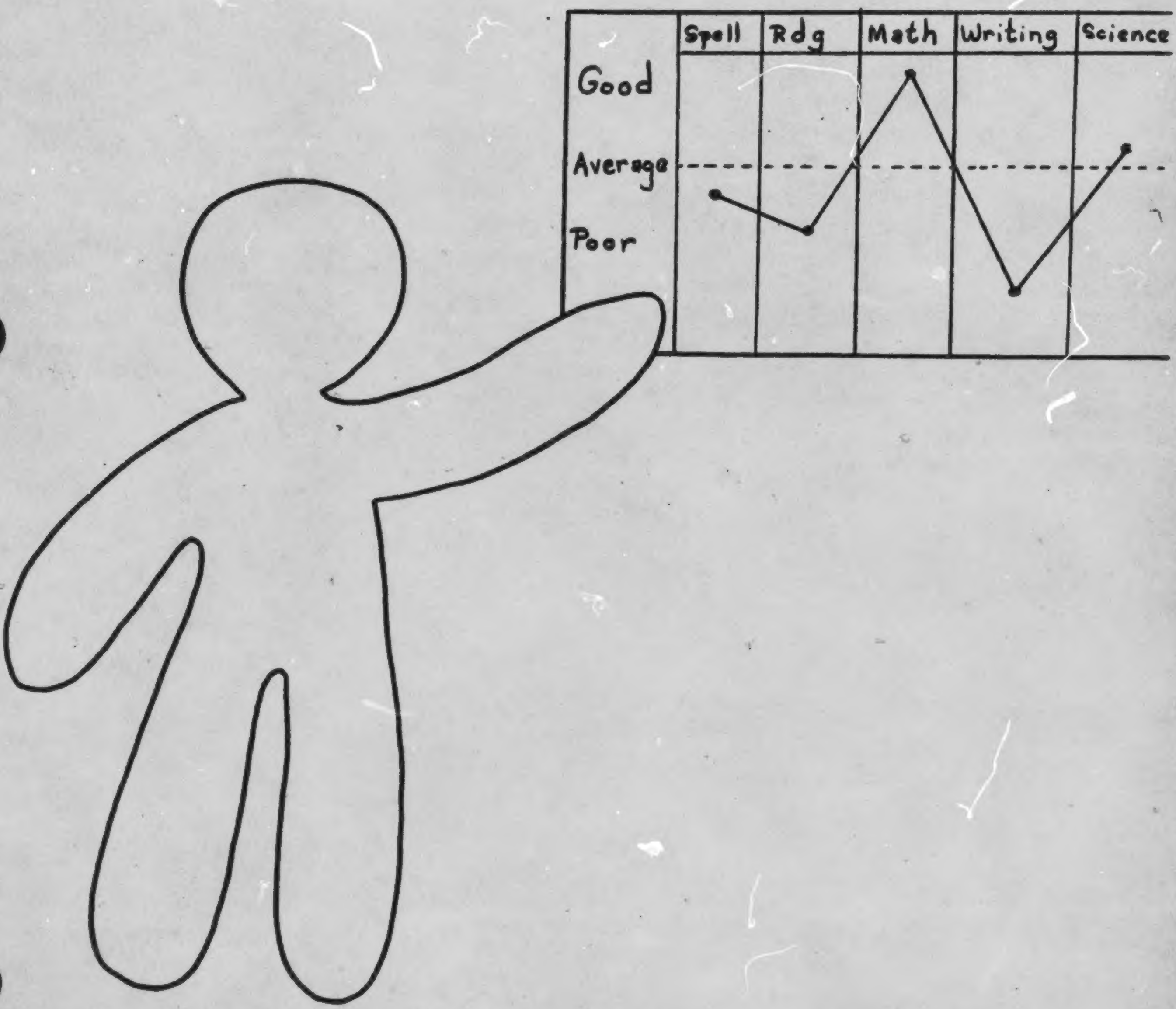
VISUAL PERCEPTION


What did you do on your vacation Johnny?
Fine, thank you Miss Jones. How are you?

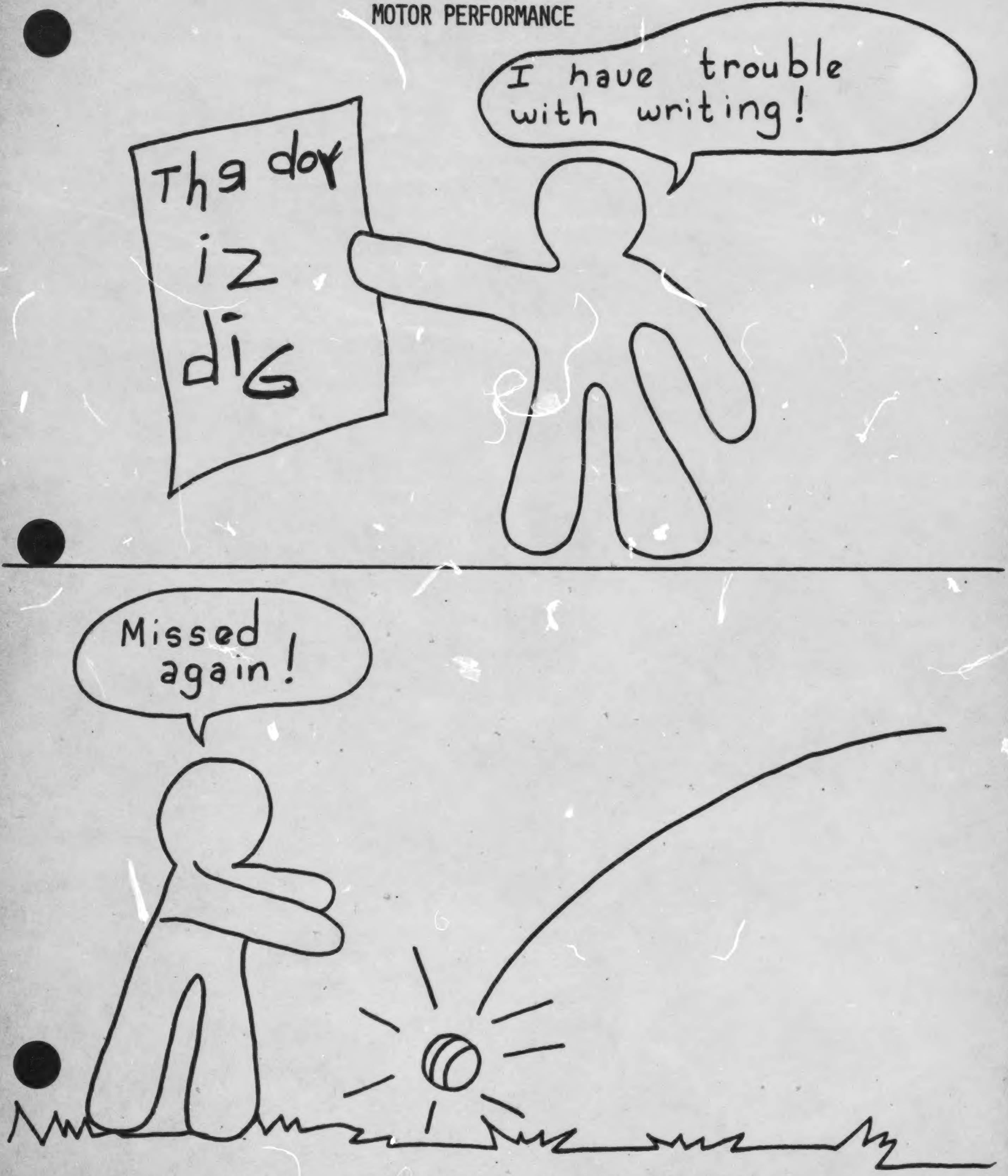

Do all the problems in the first, second, and fourth rows.
All the problems in the first and third rows?

AUDITORY MEMORY

ACADEMIC PROGRESS



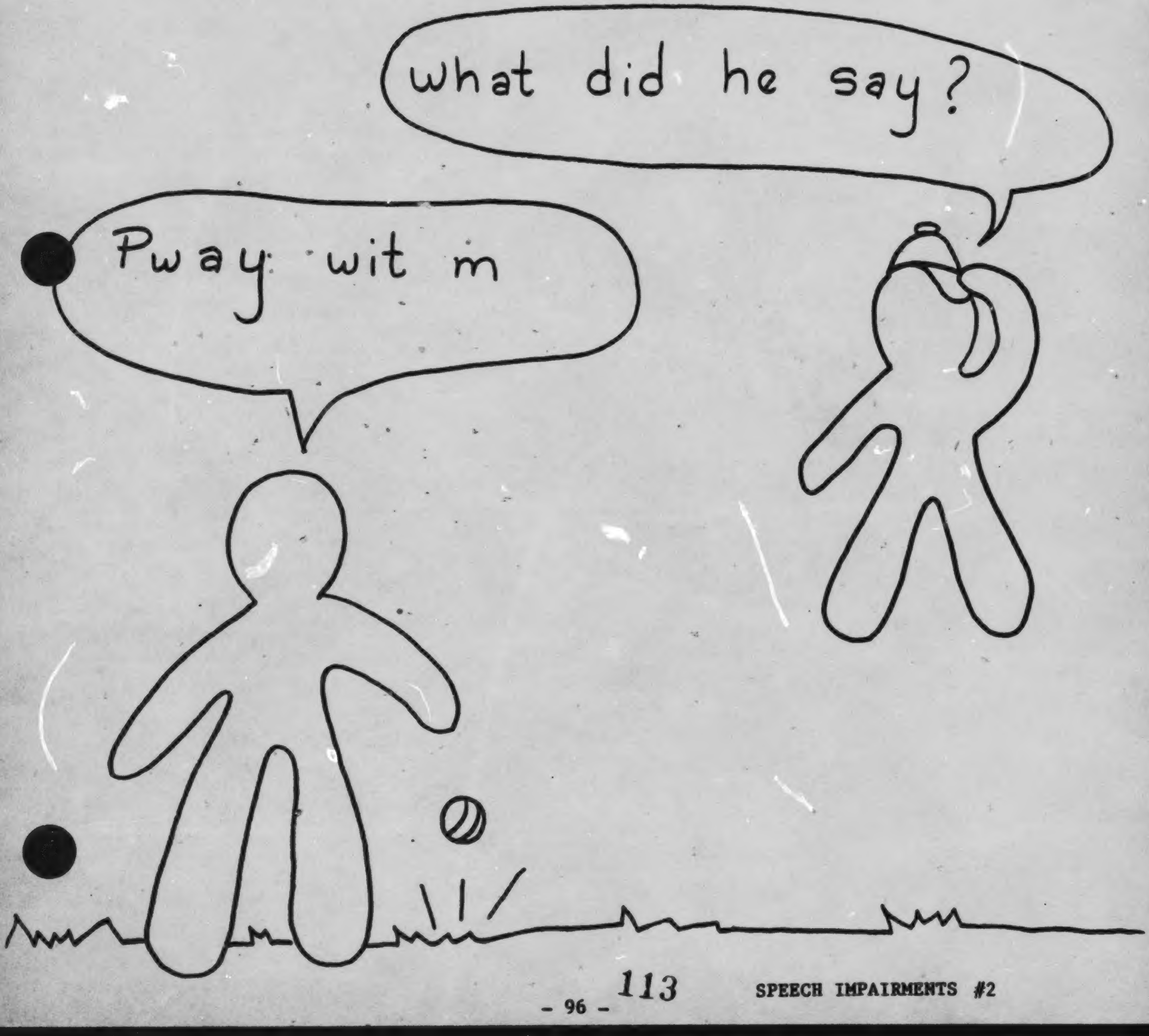
MOTOR PERFORMANCE


I have trouble with writing!
Tha dog iz diG
Missed again!

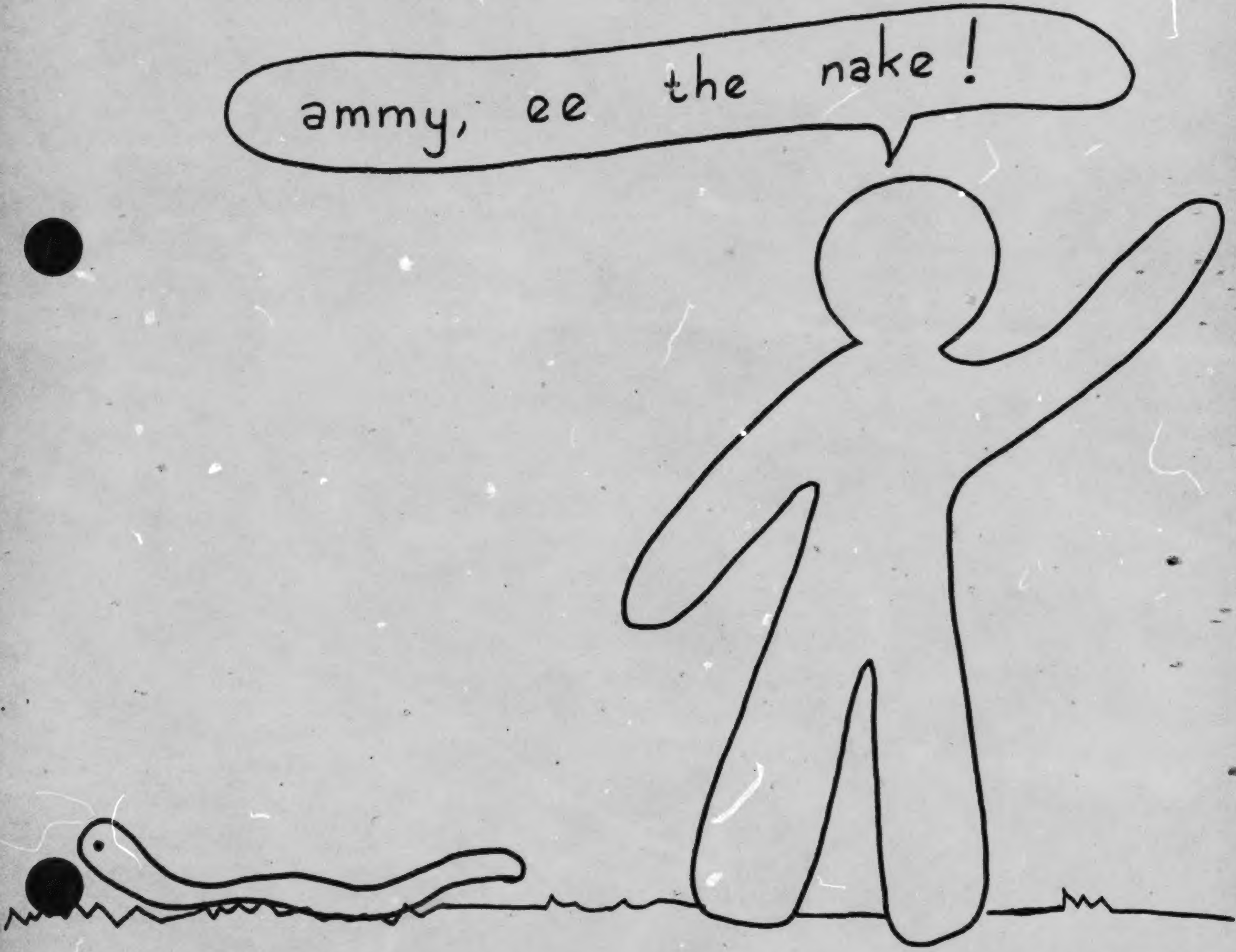
POOLE INDEX ON ORDER OF DEVELOPMENT OF CONSONANT SOUNDS

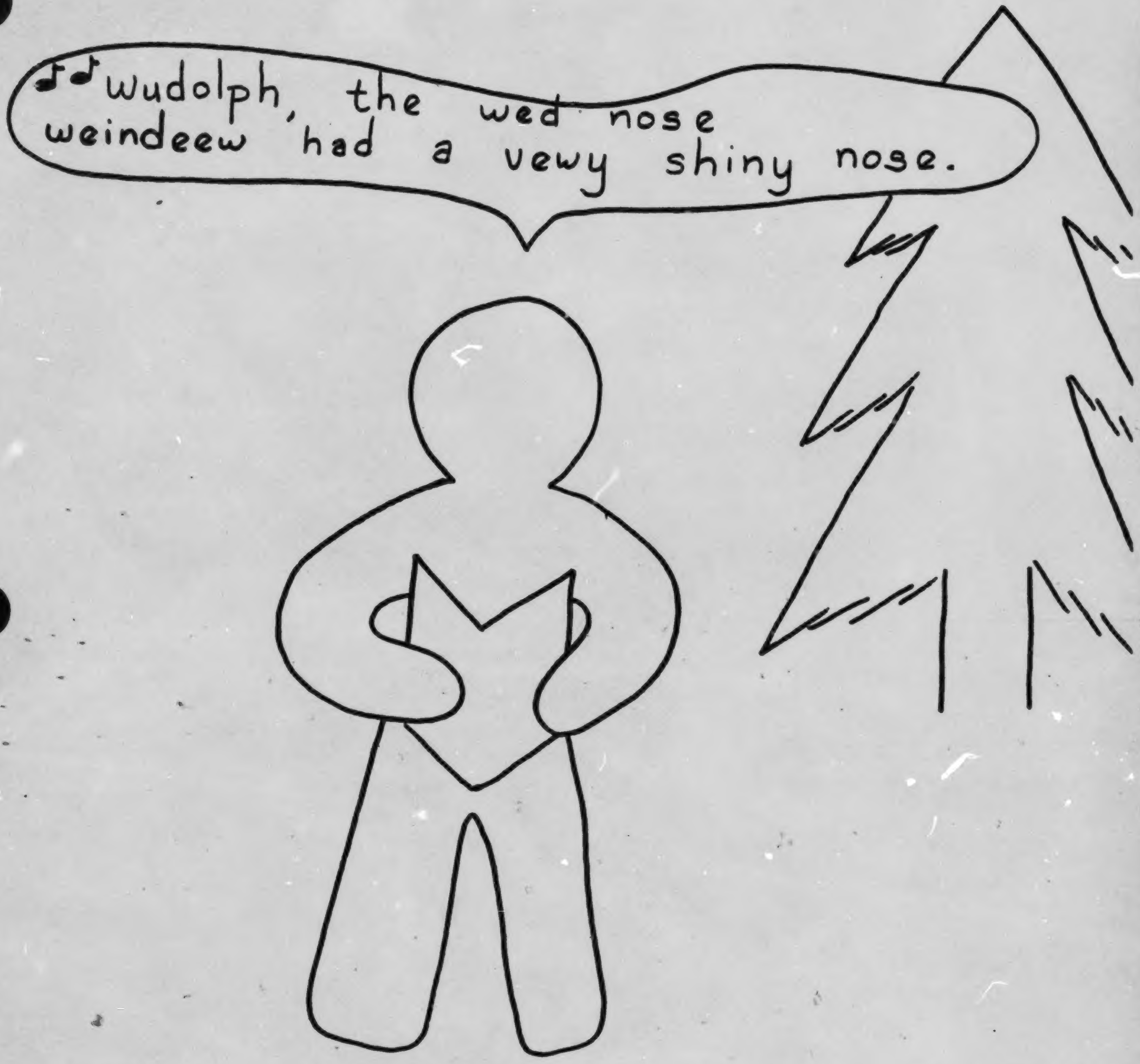
AGE	SOUNDS
3 1/2	M P B W H
4 1/2	D G K N (NG) J X Y
5 1/2	F
6 1/2	V TH SH L CH ZH
7 1/2	S R TH WH Z

ARTICULATION DISORDERS ARE THE MOST PREVELANT PROBLEM IN SCHOOL AGE CHILDREN. THE THREE TYPES OF ARTICULATION DISORDERS ARE: OMISSIONS, SUBSTITUTIONS AND DISTORTIONS.


what did he say?
Pway wit m

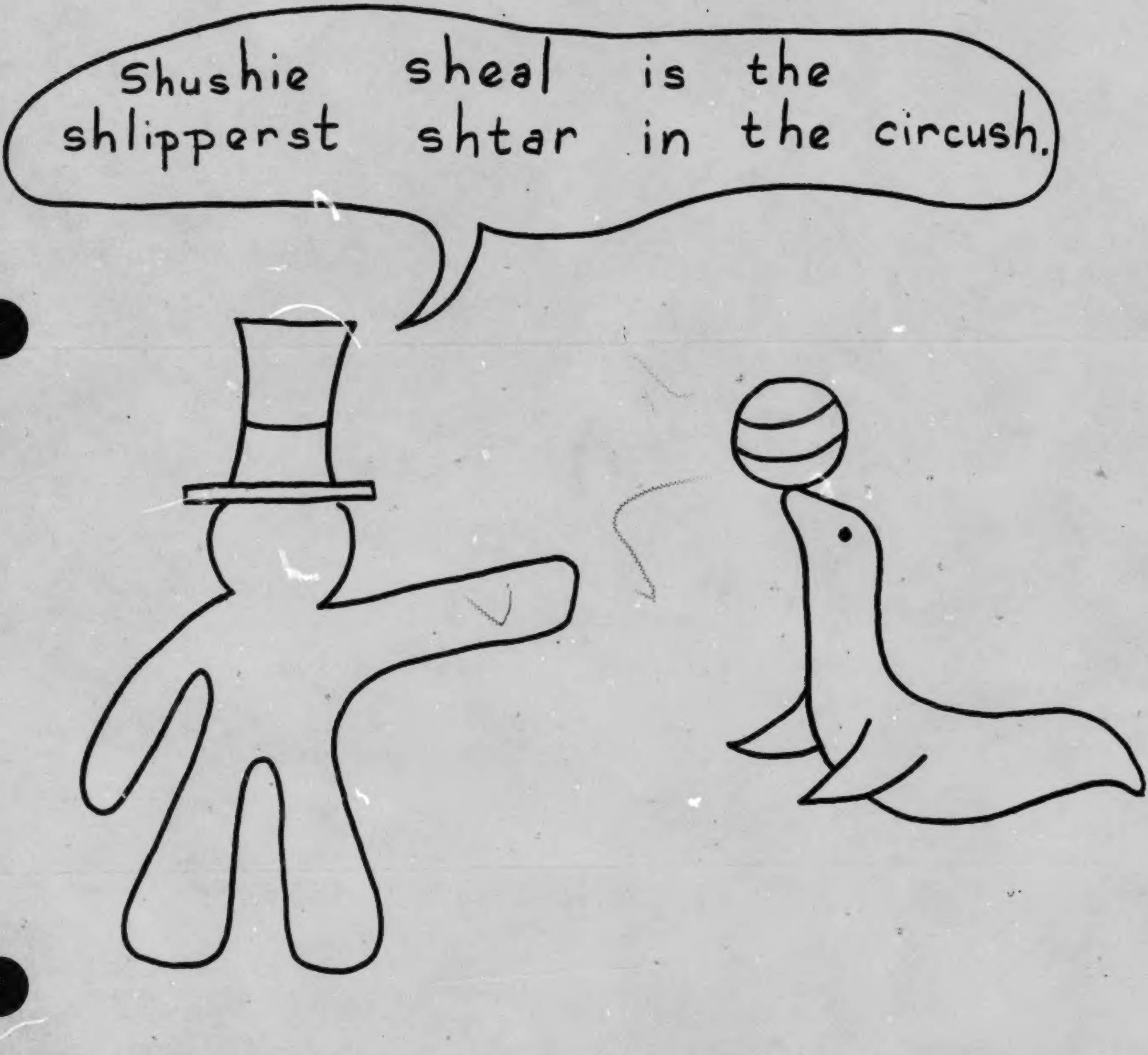
AN OMISSION OCCURS WHEN A SOUND IS OMITTED IN ALL OR SOME WORDS, PHRASES, OR SENTENCES. FOR EXAMPLE ALL "S" SOUNDS MAY BE OMITTED.


ammy, ee the nake!

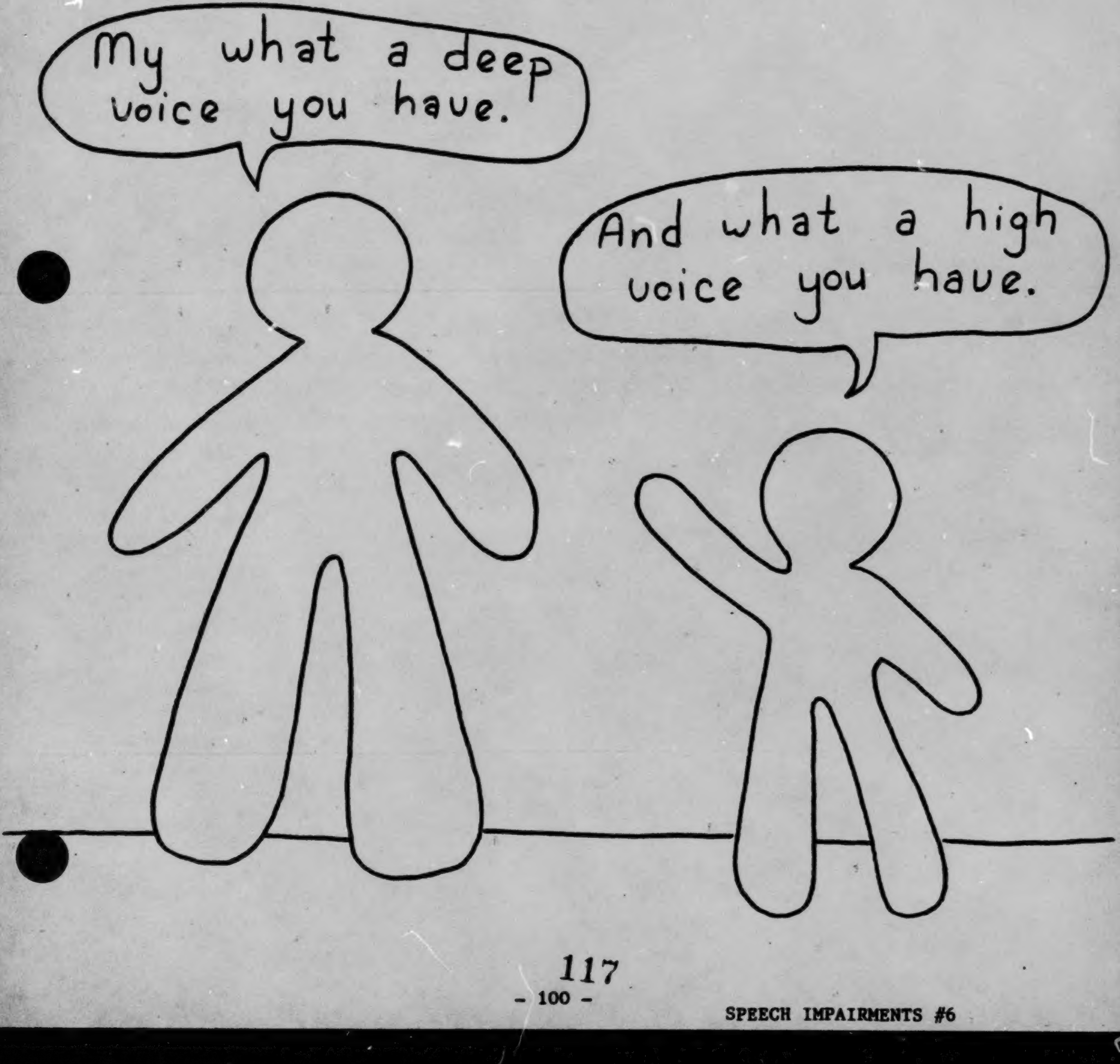

♩♩wudolph, the wed nose weindeew had a vewy shiny nose.

A SUBSTITUTION OCCURS WHEN ONE SOUND IS USED IN PLACE OF ANOTHER SOUND. THE MOST COMMON SUBSTITUTIONS ARE: "W/R", "W/L", "TH/S", AND "Y/L".

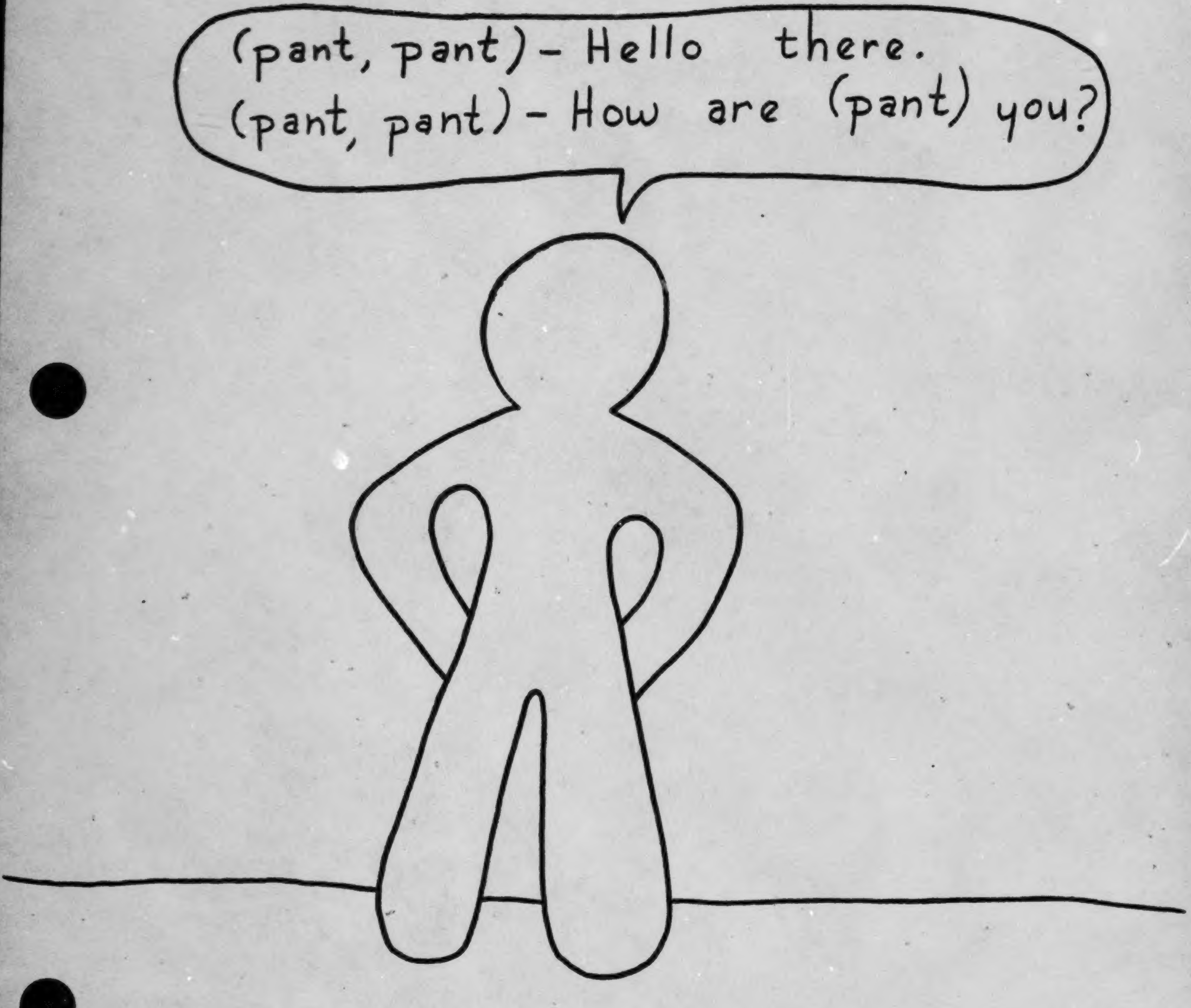
A DISTORTION OCCURS WHEN AN APPROXIMATION OF THE CORRECT SOUND IS PRODUCED. A LATERAL LISP IS A DISTORTION OF THE "S". FOR EXAMPLE "SH" CAN BE A DISTORTION OF "S".

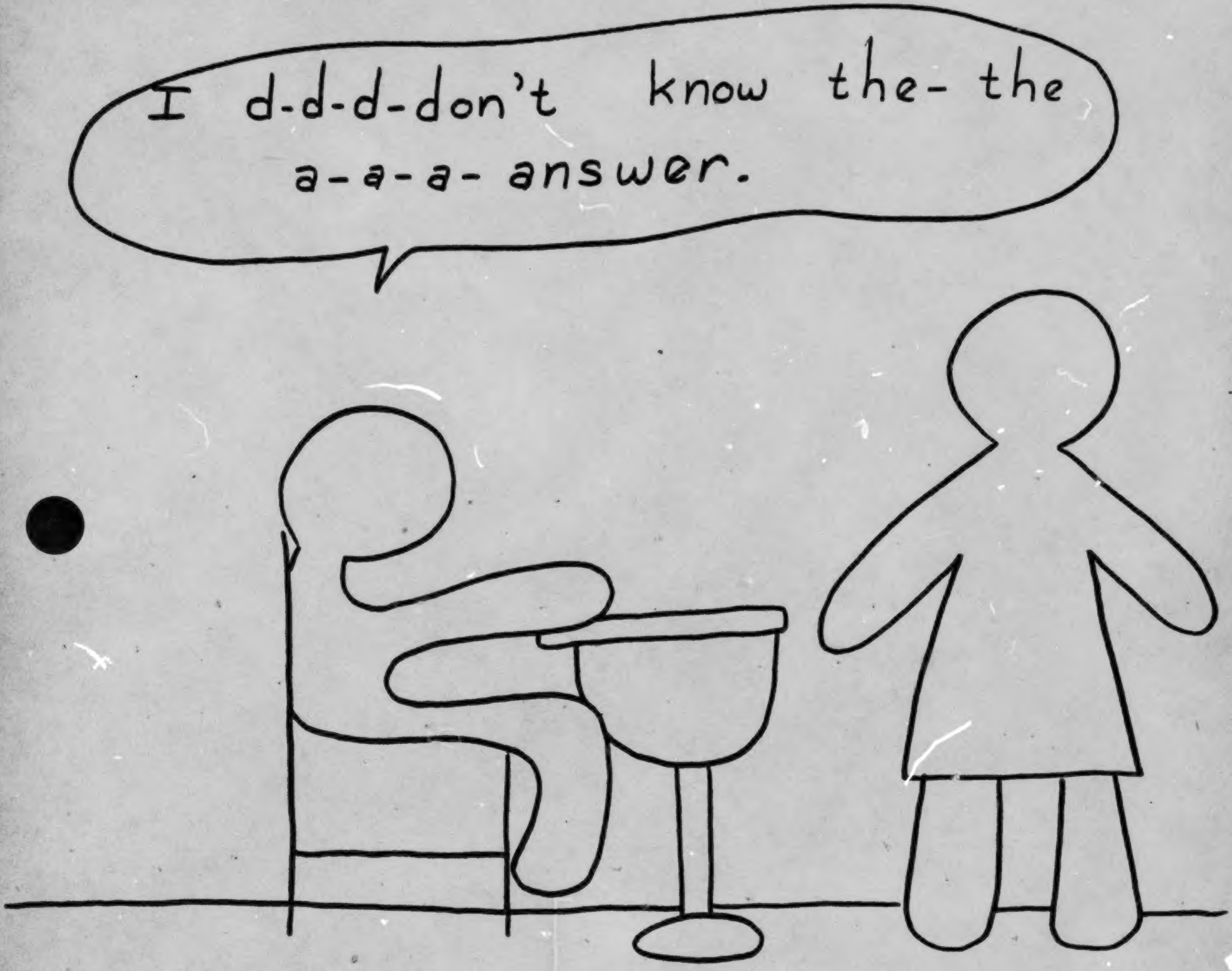

Shushie sheal is the shlipperst shtar in the circush.

A VOICE DISORDER IS ANY CHARACTERISTIC OF THE VOICE (PITCH, INTENSITY, OR QUALITY) THAT IS ATYPICAL FOR THE SPEAKER'S AGE OR SEX.


My what a deep voice you have.
And what a high voice you have.

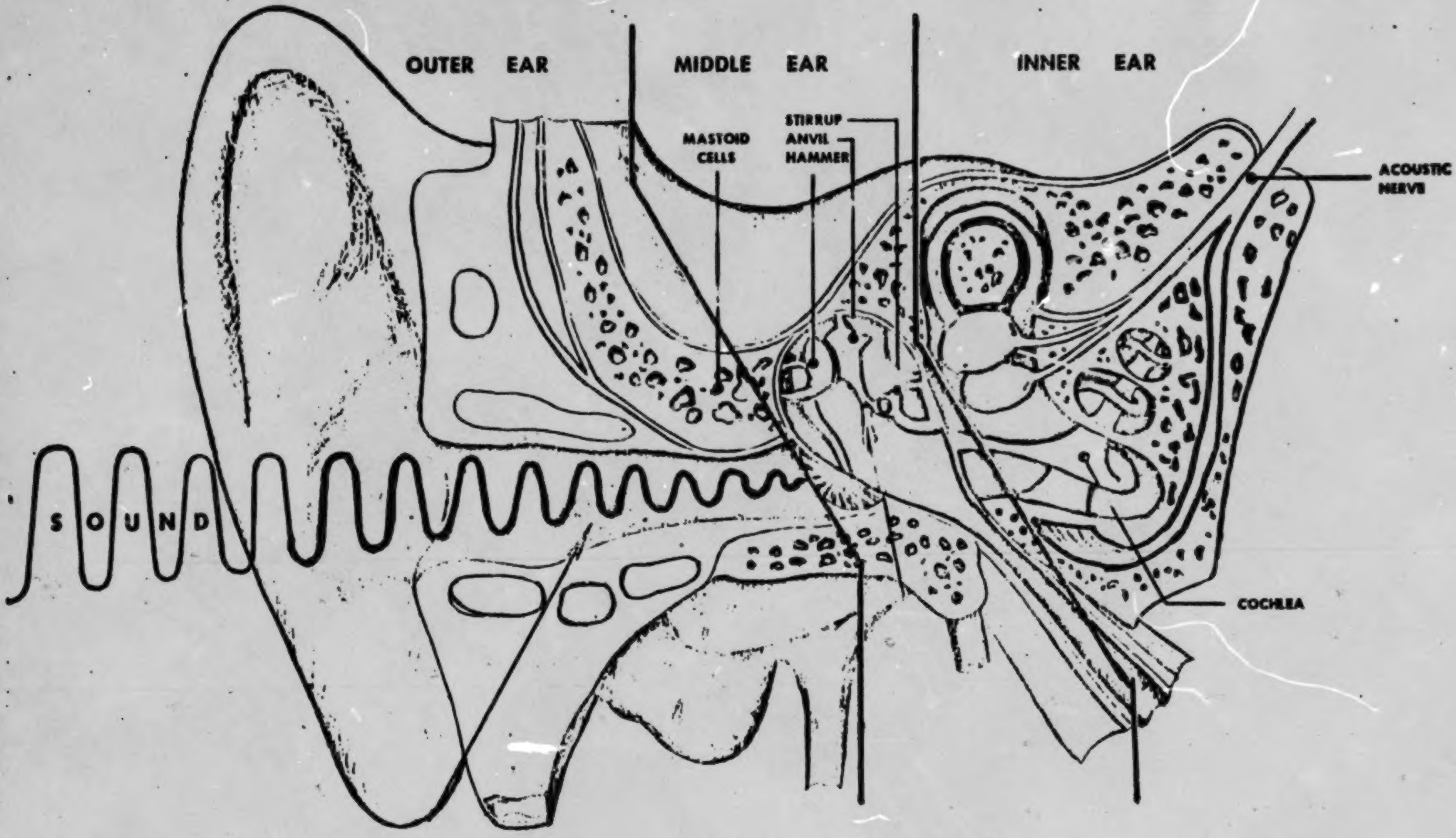
THE THREE BASIC TYPES OF VOICE DISORDERS ARE: RESPIRATION, PHONATION, AND RESONANCE.

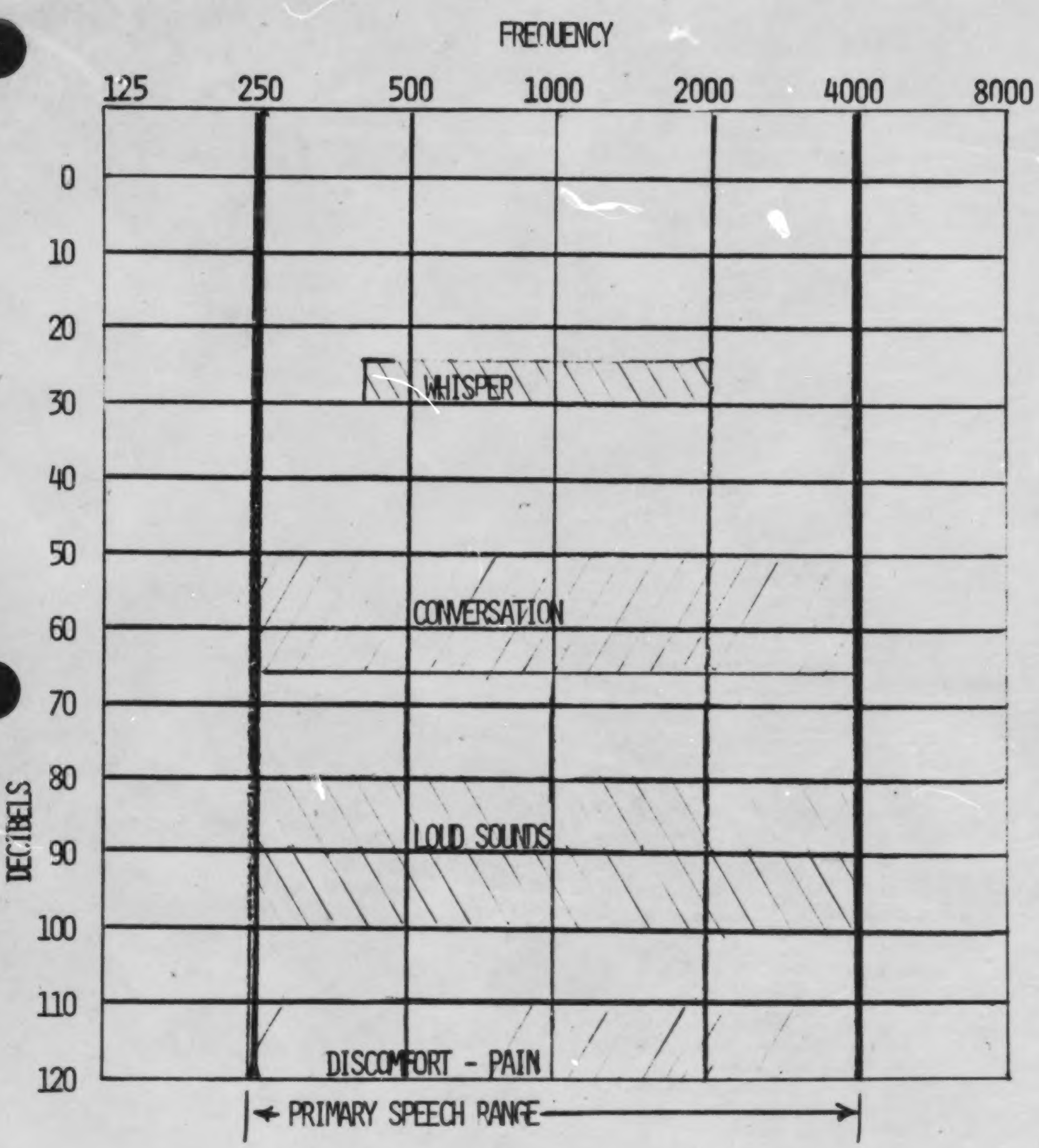

(pant, pant) - Hello there.
(pant, pant) - How are (pant) you?


I d-d-d-don't know the- the a-a-a- answer.

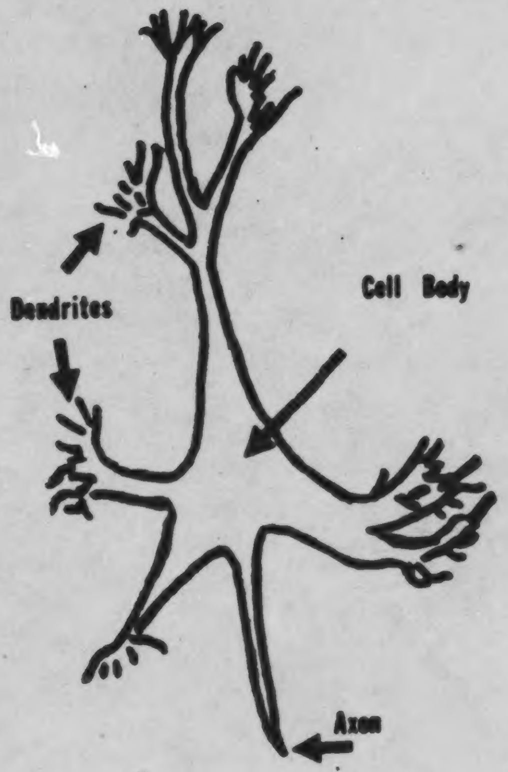
THE TYPES OF STUTTERING ARE: STOPPAGES, HESITATIONS, PROLONGATIONS, AND REPETITIONS. AS SHOWN ABOVE REPETITION IS THE REPEATED PRODUCTION OF THE FIRST SOUND, SYLLABLE, OR WORD.

Where Hearing Losses Occur


OUTER EAR
MIDDLE EAR
INNER EAR
STIRRUP
MASTOID CELLS
ANVIL
HAMMER
ACOUSTIC NERVE
SOUND
COCHLEA


FREQUENCY
125
250
500
1000
2000
4000
8000
DECIBELS
0
10
20
30
40
50
60
70
80
90
100
110
120
WHISPER
CONVERSATION
LOUD SOUNDS
DISCOMFORT - PAIN
← PRIMARY SPEECH RANGE →

122



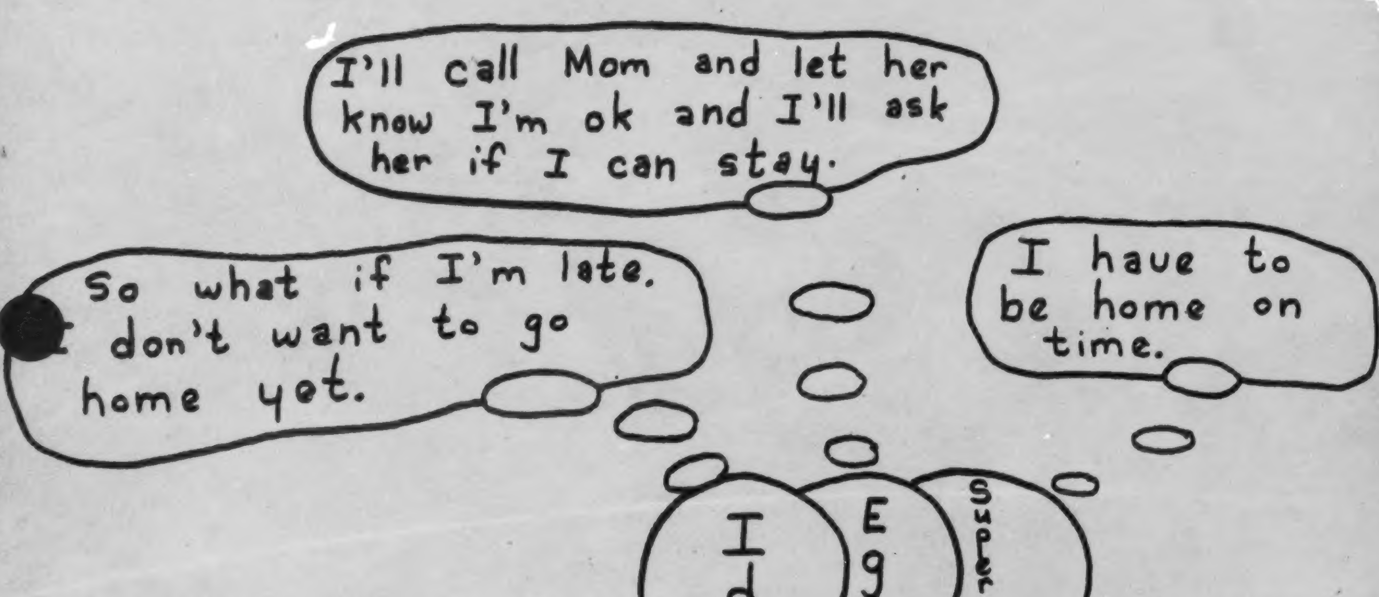
NEURON (nerve cell)

The human brain contains billions of these microscopic, threadlike, nerve cells. Dendrites conduct information to the cell body, and the axion conducts from the cell body to other nerve cells or muscles fibers

THE ID IS THE UNCONSCIOUS ASPECT OF THE PERSONALITY. IT IS A PRIMITIVE URGE STRIVING FOR PHYSICAL PLEASURE.

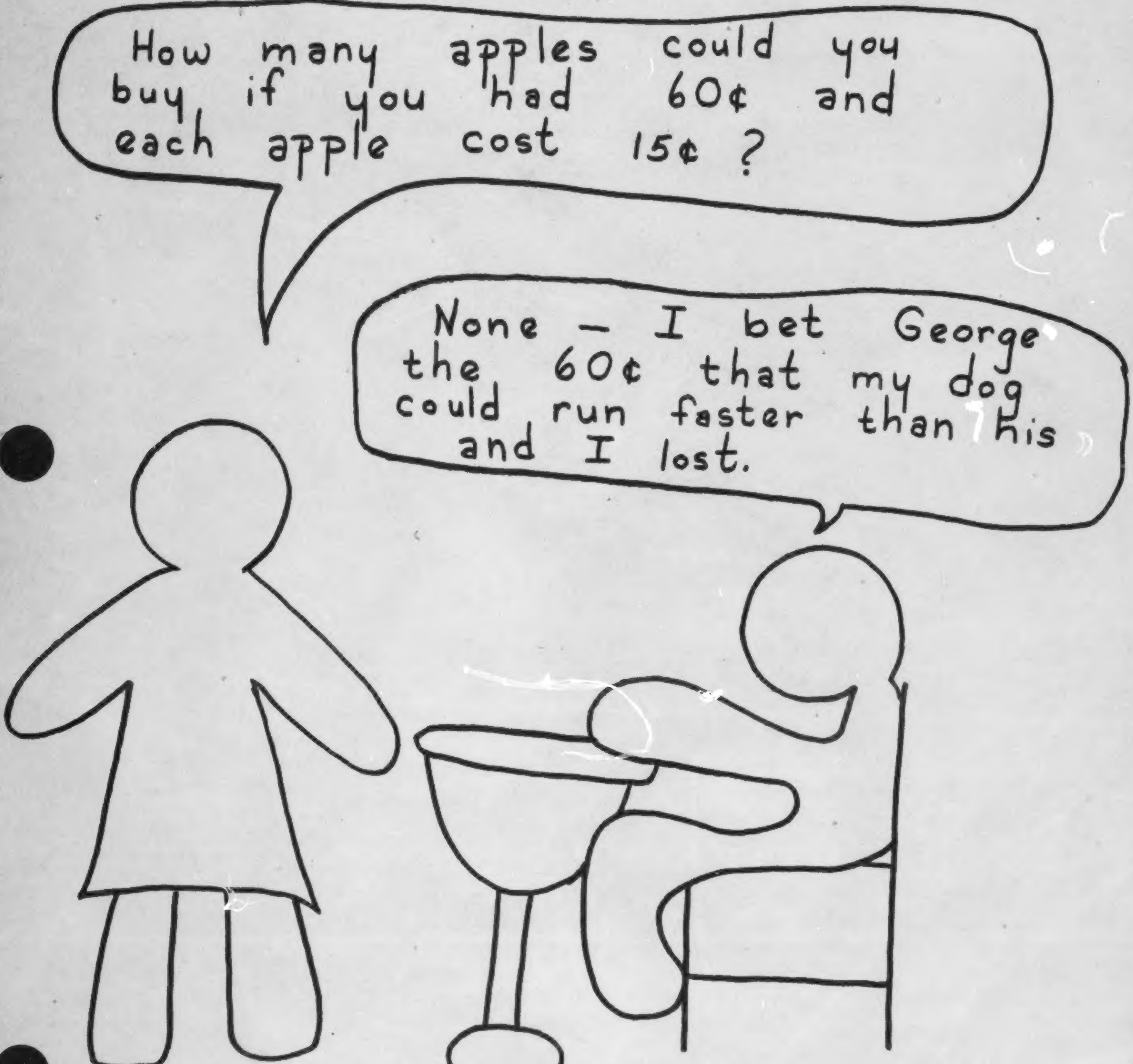
THE SUPEREGO IS A PERSON'S CONSCIENCE, AN INHIBITING, VERY IDEALISTIC FORCE.

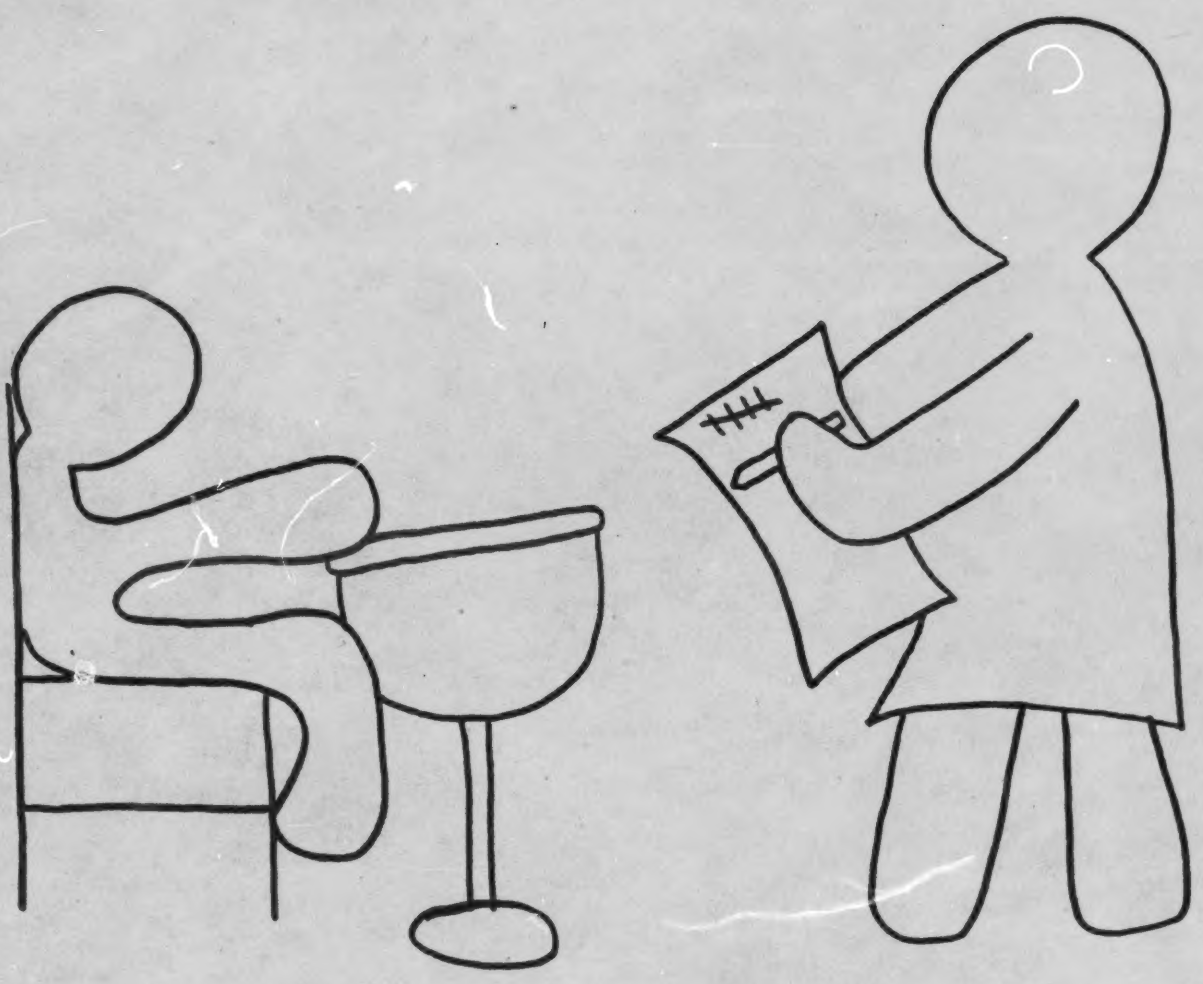
THE EGO ACTS AS A MODERATOR BETWEEN THE ID AND THE SUPEREGO. IN A HEALTHY PERSONALITY IT IS THE DECISION MAKER WITHOUT BEING OVERPOWERED BY THE ID OR THE SUPEREGO.


I'll call Mom and let her know I'm ok and I'll ask her if I can stay.
So what if I'm late. I don't want to go home yet.
I have to be home on time.
Id
Ego
Superego

SCHOOL EXAMPLE

WHEN JOHNNY WAS CALLED ON IN CLASS HE ACTED LIKE THE CLASS CLOWN RESPONDING WITH A SILLY ANSWER.

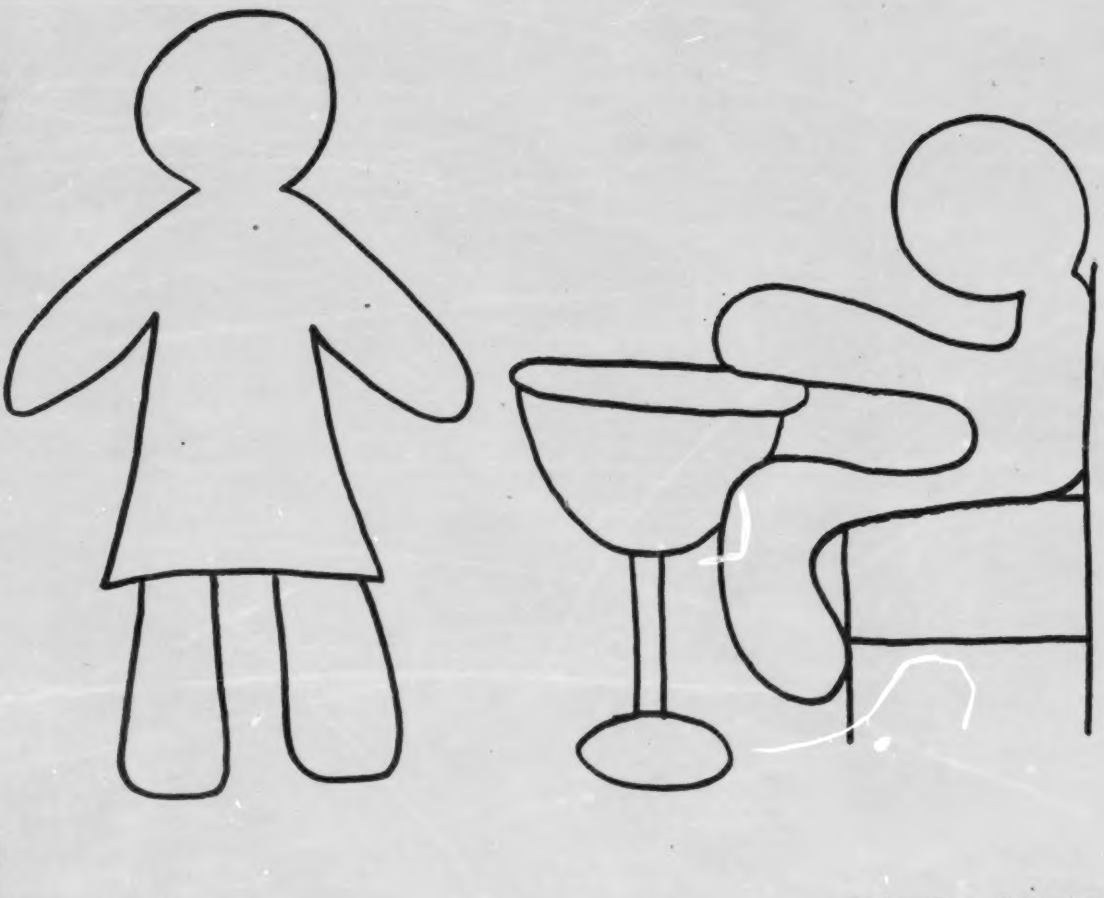

How many apples could you buy if you had 60¢ and each apple cost 15¢ ?
None – I bet George the 60¢ that my dog could run faster than his and I lost.



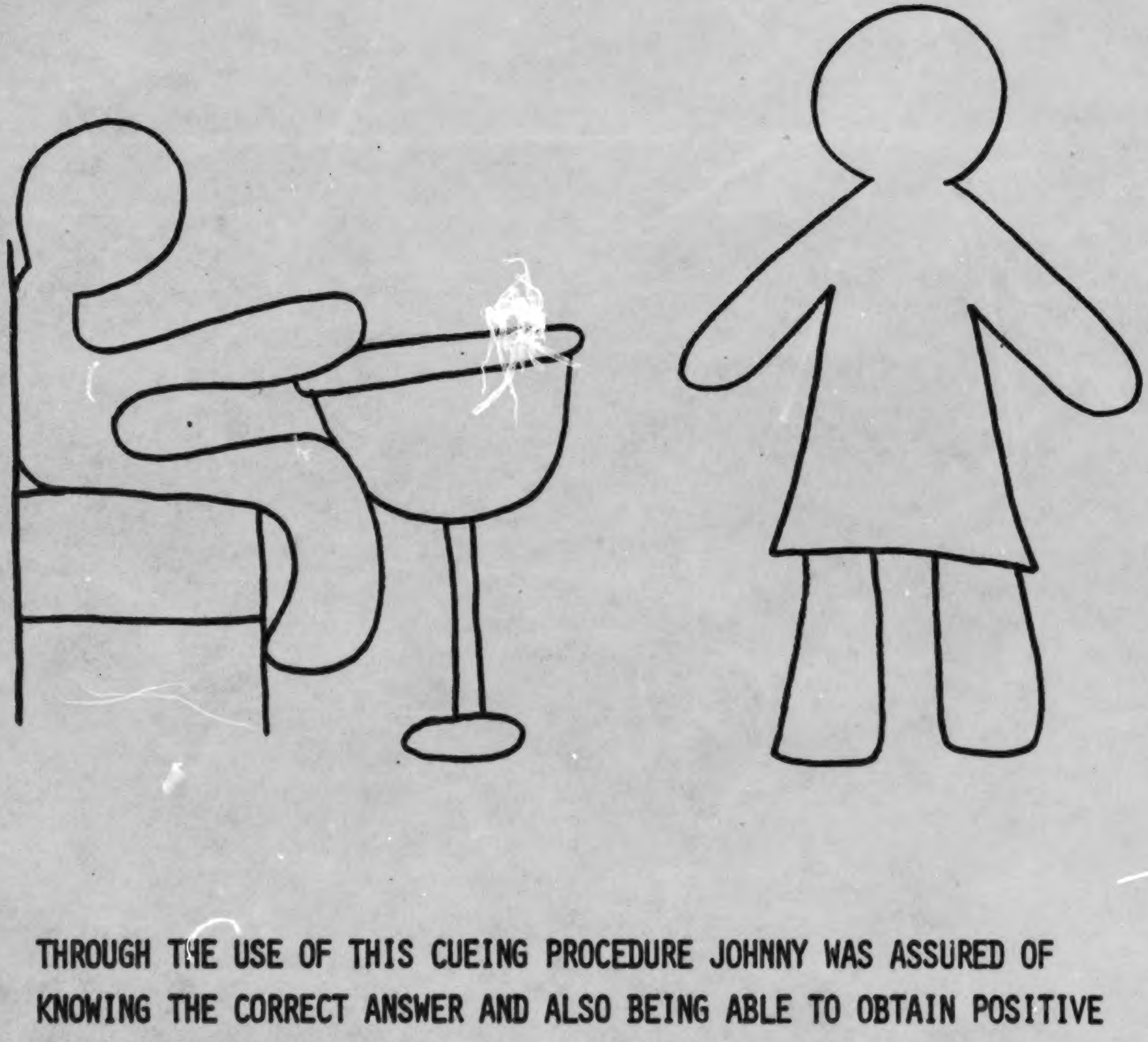
JOHNNY'S TEACHER DECIDED TO TRY TO CHANGE HIS BEHAVIOR. FIRST SHE COUNTED THE NUMBER OF TIMES HE RESPONDED WITH A SILLY ANSWER WHEN ASKED A QUESTION.

Behavior Disorders #3

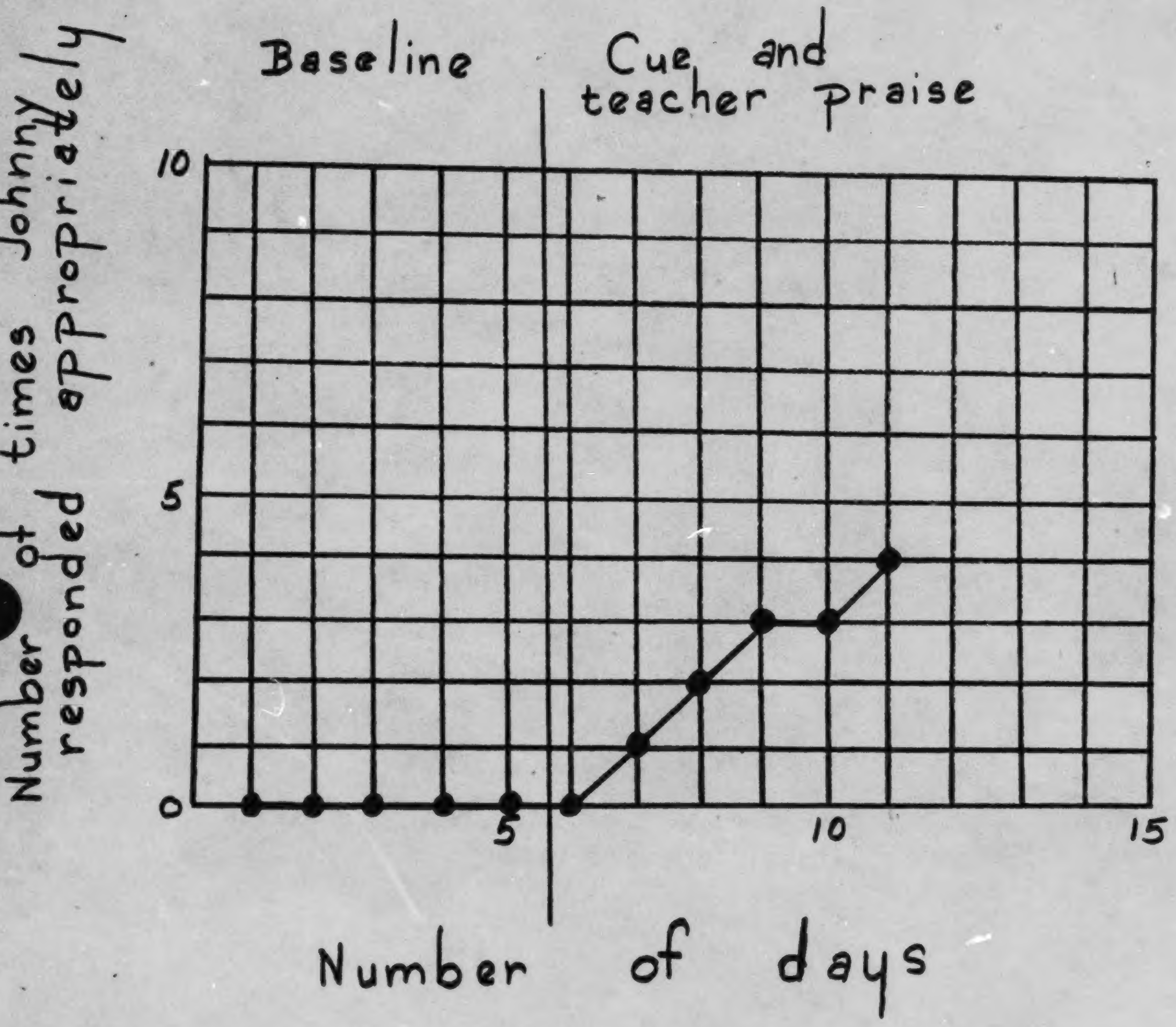
USING A COUNTING PROCEDURE FOR SEVERAL DAYS, JOHNNY'S TEACHER OBTAINED BASELINE DATA SO THAT HIS PROGRESS COULD BE MEASURED. THEN SHE IMPLEMENTED A PLAN TO HELP JOHNNY BY USING A REINFORCER PLUS A CUEING TECHNIQUE. SHE FIRST ASKED OTHER CHILDREN THE QUESTION SHE INTENDED TO ASK JOHNNY. SHE PRAISED THE OTHER CHILDREN WHEN THEY RESPONDED APPROPRIATELY.



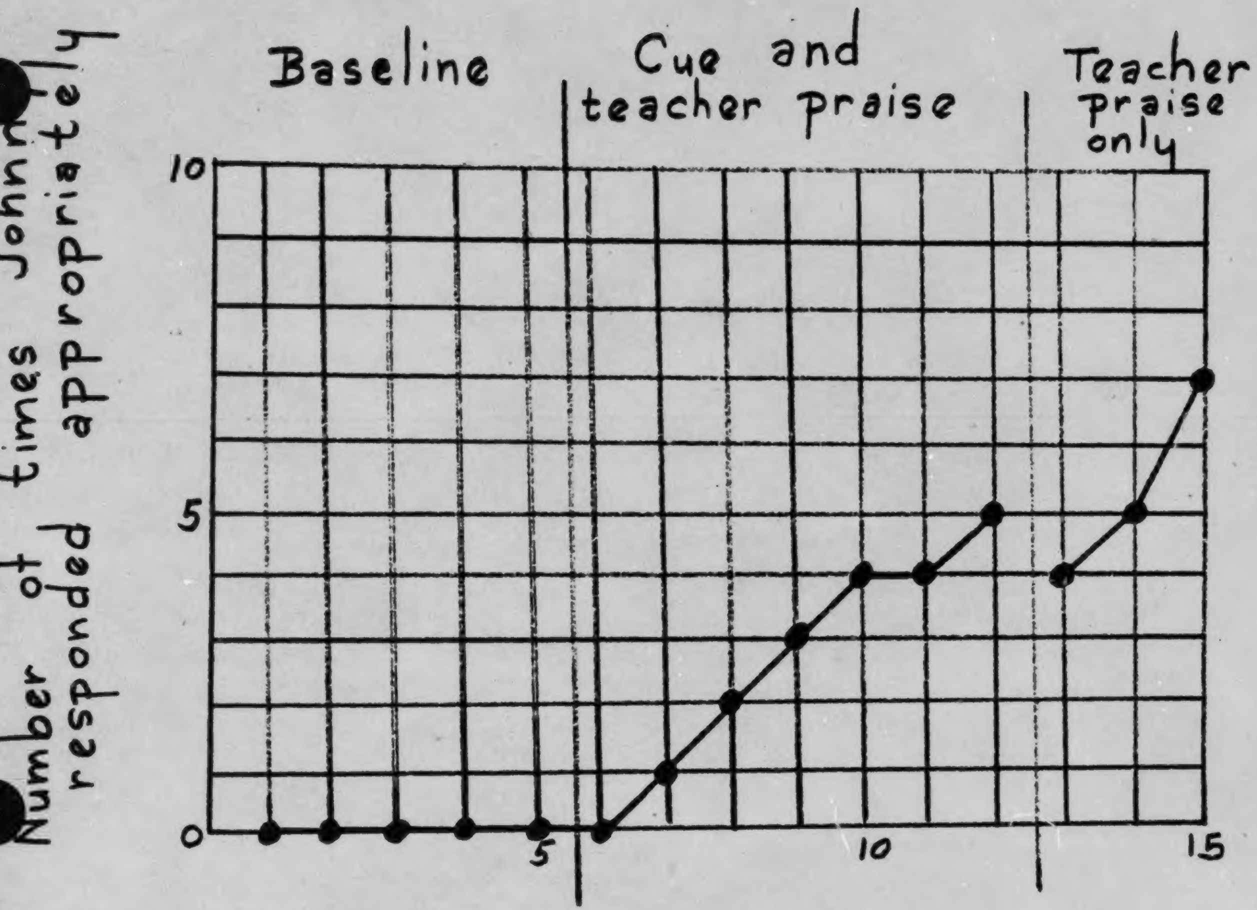
Behavior Disorders #4



THROUGH THE USE OF THIS CUEING PROCEDURE JOHNNY WAS ASSURED OF KNOWING THE CORRECT ANSWER AND ALSO BEING ABLE TO OBTAIN POSITIVE REINFORCEMENT (PRAISE).

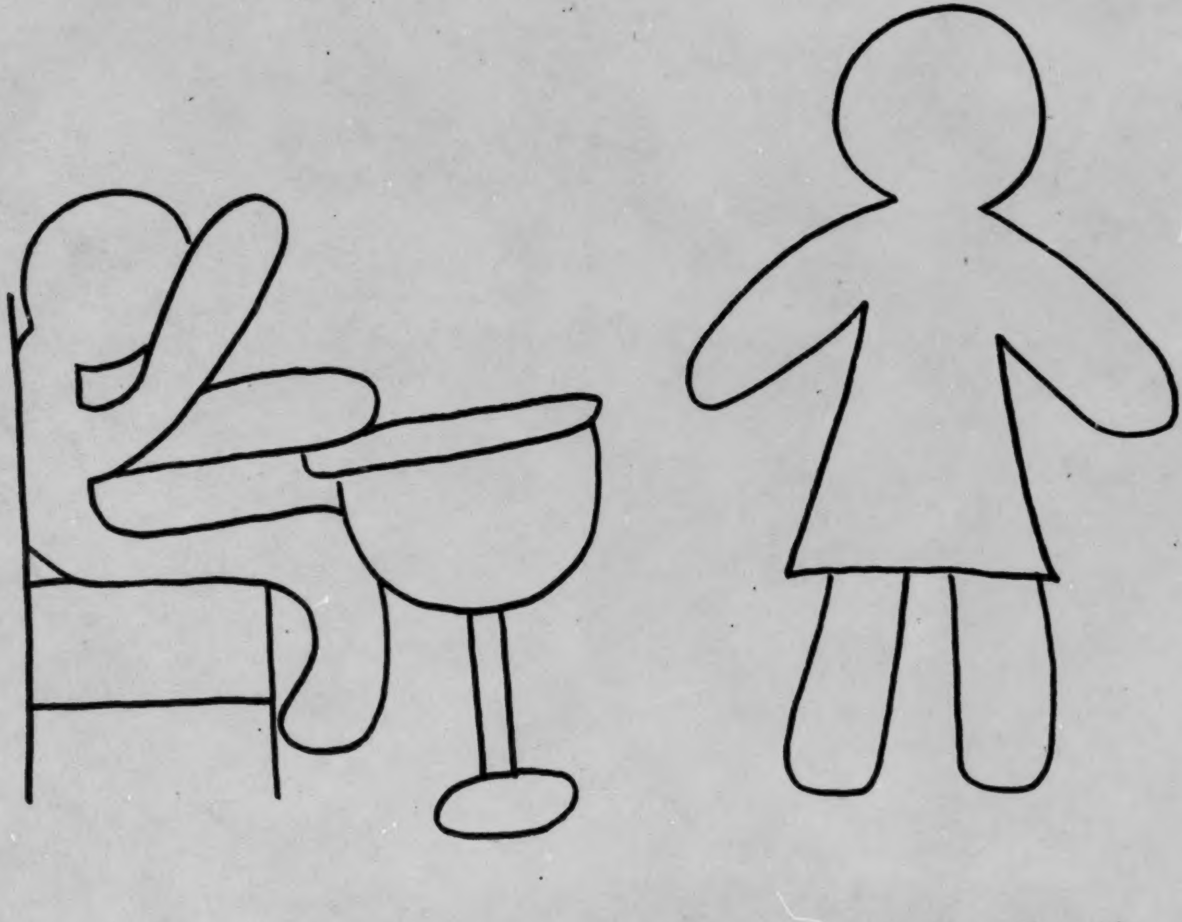


THEN JOHNNY'S TEACHER ASKED HIM THE QUESTION, IMPROVEMENT IN HIS BEHAVIOR OCCURRED.



SOON JOHNNY'S TEACHER CHANGED THE PROCEDURE SLIGHTLY. SHE DIDN'T ASK OTHER CHILDREN THE QUESTION FIRST BUT CONTINUED TO PRAISE JOHNNY FOR APPROPRIATE RESPONSES. THE QUESTIONS SHE ASKED JOHNNY WERE VERY SIMPLE ONES THAT SHE WAS SURE HE KNEW THE ANSWER TO - HE CONTINUED TO SHOW IMPROVEMENT.

THROUGH THE USE OF THIS PROCEDURE JOHNNY'S BEHAVIOR CHANGED. EVENTUALLY HE DID NOT NEED "SPECIAL TREATMENT".



Behavior Disorders #8

PROJECT: C.H.A.N.G.E.
SESSION #8

PRIMARY CURRICULUM

GRADE K-3

UNITS

I NORMAL HEALTH

II SENSES

III ACCEPTANCE OF INDIVIDUAL DIFFERENCES

IV DISABILITY: BLINDNESS

V DISABILITY: DEAFNESS

VI DISABILITY: PHYSICAL HANDICAPS

VII ACCEPTANCE OF HANDICAPS

PROJECT: C.H.A.N.G.E.
SESSION #8

INTERMEDIATE CURRICULUM

GRADE: FOUR

UNITS

I ACCEPTANCE OF SELF & OTHERS (HANDICAPPED & NON-HANDICAPPED)

II PHYSIOLOGY OF THE EYE

III DISABILITY: BLINDNESS

IV PHYSIOLOGY OF THE ENDOCRINE SYSTEM

V DISABILITY: DIABETES

PROJECT: C.H.A.N.G.E.
SESSION #8

INTERMEDIATE CURRICULUM

GRADE: FIVE

UNITS

I ACCEPTANCE OF SELF & OTHERS (HANDICAPPED & NON-HANDICAPPED)

II PHYSIOLOGY OF THE EAR

III DISABILITY: DEAFNESS

IV PHYSIOLOGY OF THE ORAL MECHANISM

V DISABILITY: SPEECH IMPAIRMENT

PROJECT: C.H.A.N.G.E.
SESSION #8

INTERMEDIATE CURRICULUM

GRADE: SIX

UNITS

I ACCEPTANCE OF SELF & OTHERS (HANDICAPPED & NON-HANDICAPPED)

II PHYSIOLOGY OF THE CENTRAL NERVOUS SYSTEM

III DISABILITY: EPILEPSY

IV BASIC ANATOMY

V DISABILITY: PHYSICAL HANDICAPS

PROJECT: C.H.A.N.G.E.
SESSION #8

JUNIOR HIGH CURRICULUM

GRADE: SEVEN

UNITS

- I ACCEPTANCE OF SELF & OTHERS (HANDICAPPED & NON-HANDICAPPED)
- II CEREBRAL FUNCTION
- III DISABILITY: MENTAL RETARDATION
- IV DISABILITY: LEARNING DISABILITIES
- V DISABILITY: EMOTIONAL PROBLEMS

PROJECT: C.H.A.N.G.E.
SESSION #8

JUNIOR HIGH CURRICULUM

GRADE: EIGHT

UNITS

I ACCEPTANCE OF SELF & OTHERS (HANDICAPPED & NON-HANDICAPPED)

II REVIEW OF DISABILITIES AND REHABILITATION

III HEALTH CAREERS (HANDICAPPED & NON-HANDICAPPED)

PROJECT: C.H.A.N.G.E.
SESSION #8

FORMAT OF THE TEACHER MANUAL

EACH UNIT INCLUDES:

1. INTRODUCTION, OBJECTIVES AND CONCEPTS
2. ACTIVITIES
    - A. OBJECTIVES
    - B. MATERIALS
    - C. PROCEDURE
3. BIBLIOGRAPHY

PROJECT: C.H.A.N.G.E.
SESSION #8

ACTIVITIES

THE LESSON PLANS INCLUDE VARIOUS TYPES OF ACTIVITIES.

1. INGENUITY ACTIVITIES
2. SIMULATION ACTIVITIES
3. LECTURES
4. CLASS DISCUSSION
5. AUDIOVISUAL MATERIALS
6. GUEST SPEAKERS

LESSON PLAN CHECKLIST

RATE THE ACTIVITY USING THIS CODE:

E - EXCELLENT
VG - VERY GOOD
G - GOOD
P - POOR
N/A - NOT APPROPRIATE

UNIT

NORMAL HEALTH

WEEKS OF:	ACTIVITY TITLE	ACTIVITY RATING				
		E	VG	G	P	N/A
9/22/80 THRU 9/26/80	______________________________	4	3	2	1	0
9/29/80 THRU 10/3/80	______________________________	4	3	2	1	0
10/6/80 THRU 10/10/80	______________________________	4	3	2	1	0

AFTER COMPLETEING THIS UNIT, TAKE ONE ACTIVITY AND EVALUATE IT ON THE UNIT EVALUATION FORM. A UNIT EVALUATION MUST BE DONE FOR EACH UNIT.

TESTING	WEEK OF
SKILL ATTAINMENT LIST (KINDERGARTENS ONLY) BY PARENT TEAM	9/15/80 THRU 9/19/80

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
UNIT EVALUATION FORM

UNIT TITLE ____________________

ACTIVITY TITLE ____________________

OBJECTIVE ____________________

OUTCOME: (STUDENT'S REACTION, COMMENTS, TEACHER'S REACTION) ______

____

____

EVALUATION: (IN TERMS OF OBJECTIVE) ____________________

____

____

EVALUATION OF ACTIVITY:

1. IF USED AGAIN, WHAT WOULD YOU CHANGE? ______________

   ____

2. IF USED AGAIN, WHAT WOULD YOU RETAIN? ______________

   ____

3. WHY DID YOU CHOOSE TO EVALUATE THIS ACTIVITY? __________

   ____

PROJECT: C.H.A.N.G.E.

ASSESSMENT INSTRUMENTS

NAME OF TEST	TO WHOM ADMINISTERED	WHAT IS MEASURED
PRIMARY ATTITUDE SURVEY	PRIMARY GRADES - (K-3)	ATTITUDES TOWARD HANDICAPS
SKILL ATTAINMENT LIST	PRIMARY GRADES - (K-3)	KNOWLEDGE OF CURRICULUM
INTERMEDIATE ATTITUDE SURVEY	4, 5, 6	ATTITUDES TOWARD HANDICAPS
JUNIOR HIGH ATTITUDE SURVEY	7, 8	ATTITUDES TOWARD HANDICAPS
SKILL ATTAINMENT LIST	4, 5, 6, 7, 8	KNOWLEDGE OF CURRICULUM
SURVEY OF DISABILITIES	TEACHERS	KNOWLEDGE OF HANDICAPS
ATTITUDE TOWARD DISABLED PERSONS	TEACHERS	ATTITUDES TOWARD HANDICAPS

UTILIZATION OF AUDIOVISUAL MATERIALS

This section is a compilation of audiovisual materials for use in the teacher training program. Districts using format 1 will want to use these materials as part of the lectures.

The materials are listed by the handicap to which they relate. Suppliers are listed next to each entry. Material should be previewed prior to presentation of the lecture.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS

BLINDNESS

Eyes of a Child (Film/Free)

HLMDC
624 East Walnut
Second Floor
Indianapolis, Indiana, 46204

Seven Minute Lesson (Film) ($62.00/may be rented)

American Foundation of the Blind
15 West 16th Street
New York, New York 10011

Still the Same Person (Film) ($40.00/may be rented)

American Foundation of the Blind
15 West 16th Street
New York, New York 10011

What to Do When You See a Blind Person (Film) ($14.00/may be rented)

American Foundation of the Blind
15 West 16th Street
New York, New York 10011

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
PHYSICAL HANDICAPS

A Day In the Life of Bonnie Consolo (Film) ($5.00 rental)	SMA - RIMIS 250 West Sibley Blvd. Dolton P.O. Box, Harvey, Illinois 60426
"Diana", People You'd Like to Know (Film) ($5.00 rental)	SMA - RIMIS 250 West Sibley Blvd. Dolton P.O. Box, Harvey, Illinois 60426
Focus On Ability (Film)	American National Red Cross General Supply Office 18 and E Street N.W. Washington, D.C. 20006
Good People (Film)	Presidents Committee on Employment of Handicapped Mr. Roland Hays Visual Information Specialist Room 662 Vanguard Building 1111 20th Street N.W. Washington, D.C. 20036
Keep on Walking (Film).	March Of Dimes National Foundations 1275 Mamaroneck Avenue White Plains, N. Y. 10605

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
DIABETES

Just one in a Crowd (set of 5 filmstrips) Free Loan	Veterans Administration Public Health Service Division of Chronic Deseases Audio-visual service Central Office Film Library (037B1) Washington, D.C., 20420
My Friend Edi (Film)	Eli Lilly and Company Mr. A. Proctor A - V Film Library P.O. Box 618 Indianapolis, Indiana 46202

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
MENTAL RETARDATION

All My Buttons (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

Becky (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

Introducing The Mentally Retarded (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

Selling One Guy Named Larry (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

The Retarded Child Parts I & II (Fs/Cass)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

The Shape of A Leaf (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

Who Will Tie My Shoe? (Film)

Illinois Office of Education
Media and Resources Center
100 North First Street
Springfield, Illinois 62777

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
LEARNING DISABILITIES

A Walk in Another Pair of Shoes (Filmstrip)	California Association for Neurologically Handicapped Children P.O. Box 604 Los Angeles, California 90053
Bright Boy, Bad Scholar (Film)	Illinois Office of Education Media and Resources Center 100 North First Street Springfield, Illinois 62777
Meet Lisa (Film)	Illinois Office of Education Media and Resources Center 100 North First Street Springfield, Illinois 62777
Why Billy Couldn't Learn (Film)	Illinois Office of Education Media and Resources Center 100 North First Street Sprinfield, Illinois 62777

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
SPEECH IMPAIRMENTS

Individual Speech Training (Film/free) AA 990034

HLMDC
624 EAST Walnut
Second Floor
Indianapolis, Indiana, 46204

"Kai", People You'd Like to Know (Film) ($5.00 rental fee)

SMA - KIMIS
250 West Sibley Blvd.
Dolton
P.O.Box, Harvey, Illinois 60426

The Speech Chain (Film/free)

Illinois Bell Telephone
Education Representative
7800 West 95th Street
Hickory Hills, Illinois 60457

Phone: (312) 598-9973

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
DEAFNESS

Lisa, Pay Attention (Film/Free)

HLMDC
624 East Walnut
Second Floor
Indianapolis, Indiana 46204

Listen (Film/Free)

HLMDC
624 East Walnut
Second Floor
Indianapolis, Indiana 46204

Sunday and Monday in Silence (Film) ($680.00/may be rented)

Heritage Visual Sales
508 Church Street
Toronto, Ontario Canada M4Y 2C8

Understanding the Deaf (Film) ($302.00/may be rented)

HLMDC
624 East Walnut
Second Floor
Indianapolis, Indiana 46204

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
EPILEPSY

"Images of Epilepsy" (Film/Free)	Colorado Epilepsy Association 1835 Gaylord Street Denver, Colorado 80206
Now Let's see Epilepsy (Film/Free loan)	National Epilepsy League 116 South Michigan Avenue Chicago, Illinois 60603

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
EMOTIONAL PROBLEMS

"Behavior Disorder", *Hello Everybody*. (Fs/cass) ($35.00)

Stanfield Associates
P.O. Box 1893
Santa Monica, Cal. 90406

"Cindy", *What is a Handicap*? (Fs/cass) ($28.00)

B F A
221 Michigan Avenue
P.O. Box 1795
Santa Monica, Cal. 90406

Emotionally Disturbed: A Time of Growing (Film/Free)

Metropolitan Life Insurance Co.
Health and Welfare Film Library
% Association-Sterling Films
512 Burlington Avenue
La Grange, Illinois 60525

Misfit (Film/Free)

Gospel Films, Inc.
P.O. Box 455
Muskegon, Michigan 49443

Santa Monica Project (Film/Free)

Aims Instructional Media Services
P.O. Box 1010
Hollywood, California 90028

Available from:

Illinois Office of Education
100 North First Street
Springfield, Illinois 62777

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
AUDIOVISUAL MATERIALS
REHABILITATION

A Different Approach. (Film/Free) South Bay Mayor's Committe, 1978.	Handicapped Learner Materials Distribution Center 624 East Walnut Second Floor Indianapolis, Indiana 46204
Everyday Champions. (Film/Free)	Illinois Bell Telephone Education Representative 7800 West 95th Street Hickory Hills, Illinois 60457
Get It Together. (Film) ($300.00) Pyramid Films, 1977.	Pyramid Films P.O. Box 1048 Santa Monica, California 90406
We Can Grow: A Film About Disabled Children. Communico, 1970. (Film/Free)	Illinois Office of Education Media and Resources Center 100 North First Street Springfield, Illinois 62777

PROJECT
CONCEPTS OF HANDICAPS AND ATTITUDES NEED GUIDANCE AND EDUCATION
CHANGE

PART III

PRESENTING THE TRAINING PROGRAM

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

INTRODUCING THE TRAINING PROGRAM

At the first session, attendance should be taken, publicity releases signed and project books distributed as teachers enter the training program room. It is advisable to have a table with these materials set-up near the entrance of the room.

A warm greeting should be extended to the participating staff and a thank you for their interest in participating in this project. An overhead entitled the Project C.H.A.N.G.E. Cascade is provided to illustrate the general program plan. Read through the overhead and answer any questions which may arise.

Explain the purpose of the project book by informing the staff that it contains the outlines for the lecture, the vocabulary list, the fact sheet, the reference list and handouts which are pertinent. At this time, the "in" and "out" procedure for the project books can also be discussed. Advise the participants that the project books along with their teacher's manual will be presented to them at the concluding session (#8).

At the beginning of each session, tell the teachers to refer to the appropriate material in their project books. It is suggested that the grade levels at which the topic will be taught is announced. Refer to the Teacher Training Program Order of Sessions for this information.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

TEACHER TRAINING PROGRAM

ORDER OF SESSIONS

		Grade levels for Topics
SESSION #1		
Scripts:	Blindness	K-3, 4, 8
	Physical Handicaps	K-3, 6, 8
SESSION #2		
Scripts:	Diabetes	4, 8
SESSION #3		
Scripts:	Mental Retardation	7, 8
	Learning Disabilities	7, 8
SESSION #4		
Scripts:	Speech Impairments	5, 8
	Deafness	K-3, 5, 8
SESSION #5		
Script:	Epilepsy	6, 8
SESSION #6		
Script:	Behavioral Disorders	7, 8
SESSION #7		
Script:	Rehabilitation Services and Health Careers	8
SESSION #8		
Script:	Presentation of Curriculum	K-8

B

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

TEACHER TRAINING PROGRAM

COURSE OUTLINE

I. DESCRIPTION:

This Training Program is concerned with the causes and problems of the following disabilities: blindness, physical handicaps, diabetes, mental retardation, learning disabilities, speech impairments, deafness, epilepsy, emotional problems and the area of rehabilitation services and health careers.

II. MODALITIES:

The Teacher Training Program is available in script (for reading/live speaker presentation), on video tapes or on audio-cassettes.

III. RATIONALE

The purpose of the Teacher Training Program is to aid teachers in an understanding of the disabilities covered in the Project C.H.A.N.G.E. curriculum for successful program implementation with their students. Emphasis will be placed on the program objectives of the Kindergarten through eighth grade curriculum.

IV. SESSION OBJECTIVES

The following objectives are competencies which have been designed for the training program. Each unit begins with a general instructional objective under which are listed the specific objectives introduced in the session

SESSION #1 .... DISABILITY: BLINDNESS

A. The teachers will understand the medical aspects and psycho-social problems associated with visual impairments.

1. Describes the history of treatment in educational terms.
2. Outlines the incidence and definitions of visual impairments.
3. Explains the categories of visual impairments.
4. States the causes and degrees of visual impairments.
5. Discusses academics and mobility in the mainstream.
6. Identifies the psychological effects of blindness.

SESSION #1 .... DISABILITY: PHYSICAL HANDICAPS

B. The teacher will understand the concept of achieving optimal willness in association with physical handicaps.

1. Contrasts the current and historic theories of physical handicaps.
2. Defines the term physical handicaps.
3. Explains the psychological aspects of loss or function.
4. Describes the images of the physically disabled as viewed by non-handicapped.
5. Lists societal factors influencing acceptance due to longevity.

SESSION #2 .... DISABILITY: DIABETES

C. The teachers will understand the characteristic symptoms associated with diabetes.

1. Graphs the historical overview of diabetes.
2. Defines the diabetes classifications and their associated stages.
3. Explains the terminology associated with diabetes.
4. States the incidence of diabetes.
5. Explains the important differences in the treatment of diabetics.
6. Describes the possible medical complications of diabetes.
7. Discusses the current research findings and proposed management systems associated with diabetes.

SESSION #3 .... DISABILITY: MENTAL RETARDATION

D. The teachers will understand basic concepts and classifications of mental retardation.

1. States the definition of mental retardation proposed by the American Association of Mental Deficiency.
2. Lists the characteristics associated with mental retardation.
3. Describes causes affiliated with mental retardation.
4. Outlines the incidence and degrees of mental retardation.

5. Summarizes historical theories in reference to academic placement and services.

SESSION #3 .... DISABILITY: LEARNING DISABILITIES

E. The teachers will understand the characteristics and causes associated with learning disabilities.

1. Plots the historical background of learning disabilities.

2. Defines learning disabilities using the "Children with Learning Disabilities Act of 1969" definition.

3. Describes the characteristics of the learning disabled student.

4. List procedures used in diagnosing a learning disability.

5. Explains several approaches used in educational remediation with the learning disabled student.

6. Cites the incidence of learning disabled individuals.

7. Summarizes the causes which are generally affiliated learning disabilities.

SESSION #4 .... DISABILITY: SPEECH IMPAIRMENTS

F. The teacher will understand the development of normal speech and the characteristics of communication disorders.

1. Lists the characteristics and classifications of defective speech.

2. Describes normal speech development using the "Poole Index on Order of Development of Consonant Sounds".

3. Explains the organic and functional causes of defective speech.

4. Graphs the incidence of communication disorders.

5. Explains the effects of a language disorders.

SESSION #4 .... DISABILITY: DEAFNESS

G. The teacher will understand the concepts and deficits caused by the loss of natural language due to a hearing impairment.

1. Lists the types of heavy loss and deafness.

2. States the causal factors corresponding with hearing impairments.

3. Relates the prevalence estimates of hearing losses.

4. Explains the developmental factors in terms of identification, perception and obstacles.

5. Describes standards of hearing measurement.

6. Cites the academic problems arising from defective hearing.

7. Describes the origins of sign language and fingerspelling.

8. Contrasts the methods of communication used by a hearing impaired individual.

SESSION #5 .... DISABILITY: EPILEPSY

H. The teachers will understand the types of seizures and avenues of first aid for epileptics.

1. Describes the historical treatments used for epilepsy.

2. Explains the cerebellum functions associated with epilepsy.

3. Cites the types and descriptions of epileptic seizures.

4. States the suggested causes of epilepsy.

5. Explains seizure control in terms of medication and first aid.

6. Relates statistical occurences of epilepsy.

7. Explores current trends and progress in the research of epilepsy.

SESSION #6 .... BEHAVIORAL DISORDERS

I. The teachers will understand the theoretical basis of behavioral disorders and the educators role in rehabilitation.

1. States the educational provisions for handicapped children.

2. Defines a behavioral disorder using the State of Illinois definition.

3. Relates statistical factors in terms of prevalence and persistance.

4. Describes the educational status in terms of intelligence and achievement data.

5. Explains the theoretical approaches associated with emotional problems.

6. Cites the Cascade System of Special Educational Services developed by Deno.

7. Describes the educational placement process.

SESSION #7 .... REHABILITATION AND HEALTH CAREERS

J. The teacher will understand the restoration (rehabilitation) and daily functioning (careers) of the disabled.

1. Describes the reference handout for support services which are related to the curriculum.

2. Explains Public Law 94-142 "The Education For All Handicapped Children Act".

3. Cites problems which are involved in the implementation of the Federal Acts.

4. Describes the roles of professionals, layman and handicapped persons in the rehabilitative process.

5. Defines health careers in terms of occupation.

SESSION #8 .... CURRICULUM PRESENTATION

K. The teachers will understand the assessment instruments and the operating procedures of the Teacher Training Manual for implementation of the Project C.H.A.N.G.E. Curriculum.

1. Explains the role of the learning center in the Project C.H.A.N.G.E. program.

2. Describes the assessment instruments used for measurement of student growth in the project.

3. Defines the use of the Teacher Training Manual during program implementation.

4. Lists the methods of obtaining guest speakers for participation in the program.

5. Outlines the objectives and concepts used in the grade level curricula

6. Describes the format of the Teachers Manual

7. Explains the Sequence of Units for program implementation.

8. Describes the teaching of the Project C.H.A.N.G.E. curriculum.

In addition, the Project: C.H.A.N.G.E. intrument Survey of Disabilities will be administered pre and post the Teacher Training Program. After the intervention with the students (teaching the program), teachers will receive a second posttest using the same instrument.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BLINDNESS OUTLINE

I. A Historical Overview.

- A. Education of the blind ignored up to the 18th Century.
- B. First institutions and individuals to take an interest in the blind.
- C. Introduction to Braille.

II. Categories of Visual Impairments.

- A. Few children with visual impairments totally blind.
- B. Degree of impairment.
- C. Causes of visual impairment.
- D. Definition of degrees of visual impairments.

III. Problems Caused by Visual Impairments.

- A. Academics.
- B. Mobility.
- C. World of a blind person.

IV. Personality and Social Factors Affecting the Blind.

- A. Society naive.
- B. Parental reactions.
- C. Objective psychological effects of blindness.

V. Conclusion

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 1

Script: Blindness

by
Mary S. Smith
Coordinator

Today, I would like to begin with a historical overview of blindness. Until the 18th Century, the education of the blind was totally ignored. During the Renaissance, blind people were put into asylums. People were never allowed to leave these asylums. The asylums served more to help the general population avoid daily confrontation with the reality of blindness than they helped the blind. Prior to the 18th Century, blind people were left to die, reduced to a life of beggary, or used to provide amusement for sighted people.

Finally in 1745, Harry Valentine became interested in work with deaf mutes and the blind. In 1784 in France, the National Institution for Young Blind People was established. The first blind school was established in Boston in 1829.

Along with these early efforts, Charles Barbier devised a system of reading raised dots. This was followed by a system of a six dot alphabet and reading system. This latter system was devised by Louis Braille. Louis Braille had been blind from the age of three, and his system which was devised in the 1850's is the same system used today.

In 1900, the first public school day classes were started for the blind. Today, 65% of blind children are served in day school classes.

Few visually impaired children are totally blind. It has become traditional to define children with visual disabilities on a medical and psychological basis according to visual acuity and field of vision. Categories of visual handicaps for educational purposes are:

1) Children with visual defects which can be corrected through medical treatment or optical aids. (These children are not regarded as handicapped.)

2) Children whose vision is quite defective, even after correction, but are still able to read print. These children are classified as visually impaired.

3) Children who are blind and require instruction primarily through other senses.

The degree of impairment in regard to these categories depends on the eye itself. A person is classified as legally blind when his or her central visual acuity is 20/200 or less in the better eye with glasses. Of all the exceptionalities, visual impairments occur the least.

Visual impairment may be caused by injury to the unborn child, disease, an accident with a sharp object or a fall, heredity, or retrolental fibroplasia. It should be noted that the cause and the age at onset is an important factor in explaining an individual reaction to this handicap, and the parents reaction to it. The cause and age of onset also influence the parental attitude toward the child.

There are three ways in which pathological conditions of the eye may result in impaired vision:

1) The visual acuity may be reduced.
2) The field of vision may be limited or defective.
3) The color vision may be imperfect.

Visual acuity is measured by the Snellen Chart and expressed in the form of a fraction. It was stated before that the person whose vision is 20/200 in the better eye with glasses is termed legally blind. This means that what a normal eye can see at 200 feet, the blind person can see at only 20 feet.

The field of vision may be affected in two ways; an eye may have central vision with limited peripheral vision or the eye may have a scotoma which is a spot without vision. If this blind spot is in the central field of vision, it may cause loss of central vision. Color vision is determined by discrimination of three qualities of color, hue, saturation and brightness.

There are several problems encountered by people with visual impairments. Educationally, children with visual impairments must depend upon other senses. For gathering information, they must depend on tapes or braille, although the majority of legally blind children read print rather than braille. Children who are ambidexterous read braille more quickly than others. Right-handed children read braille faster than left-handed children. Since most read print, large print and tactile or other sensory methods can be used. Contrary to popular belief, eyes do not suffer from use.

Eyes are visual receptors just like a camera. Blind people's eyes do not get worse by using the vision they do have.

Although the mobility of the blind may be limited, it need not necessarily be. Children can be trained into their environment by mobility instructors or visually impaired teachers. It is easier if there are no stairs or dangerous construction in the building or if elevators have been installed with braille markings. Sighted classmates can often be assigned to the visually impaired child to help him change rooms or find his desk in the class. A stable location for desks or chairs in the room can help the child find his own way. Some children use aids such as a cane to help them negotiate their way. Children who are blind have an I.Q. spread over the same range as sighted people.

The blind person's perception of the world varies with the age of onset. A child who becomes blind before the age of five has practically no frame of reference whereas a child who becomes blind at the age of five or later may retain a more or less active visual frame of reference. Blind people can observe only those things which are accessible to them. The sun, moon and stars are inaccessible and can be explained only by the use of analogies from other sensory fields. Objects in motion, live objects and objectives in certain conditions such as fire, boiling liquids, thermometers, cannot be observed by touch because either they change shapes or positions or direct contact would be dangerous. Blind people are not superior to the sighted in their sensory acuteness. A memory for sensations is a reward for persistent effort. Blind people dream, but without visual sensation. The other senses are included in the dream along with a prominent spoken statement.

Special class placement is only needed for 1 in 1,000 visually impaired children due to their cognitive compensation.

Personality and social factors of the blind are influenced by the societal attitudes of others toward their handicap. Most of society is naive, lacking understanding and overlying pitying.

The reaction of parents toward their blind children falls into five different categories:

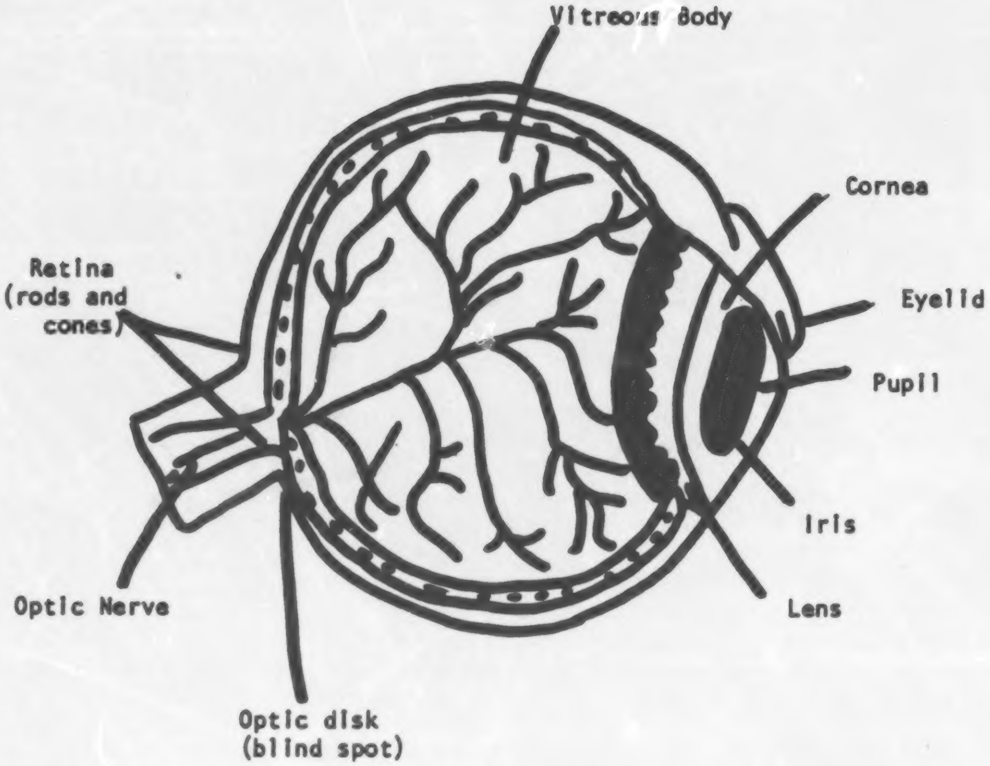
1) Parents may display genuine acceptance and devotion to the child.
2) They may display an attitude of denial, that neither they nor the child is affected.
3) They may display overprotectiveness and be over-pitying.
4) They may show thinly disguised rejection.
5) They may even in some cases overtly reject the child.

These reactions are similar in parents having all types of handicapped conditions.

Three objective effects of blindness that affect the child psychologically are the limitation in the range and variety of experiences, the limitation in the ability to get about, and the limitation in controlling the environment and themselves in relation to it.

The congenitally and totally blind experience the world through the senses and thus store knowledge of the world around themselves differently than sighted children. It is impossible for the sighted to imagine the world of the blind, just as the blind person can make no images of our world as his eyes have never seen, nor has his brain pictured. The blind person must recognize his handicap, his aspirations in a sighted world and identify himself as a person rather than as blind. In reality, we are all blind, yet we see, for it is in feelings that we have sight.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
FUNCTIONS OF THE NORMAL EYE


Vitreous Body
Cornea
Eyelid
Retina (rods and cones)
Pupil
Iris
Optic Nerve
Lens
Optic disk (blind spot)

SIGHT - Light rays enter the eye and strike the rods and cones of the retina. These specialized endings of the optic nerve are stimulated and impulses pass throuth the optic track back to the visual center of the brain and enables us to see.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BLINDNESS VOCABULARY LIST

1. Visual impairment - refers to the physical loss or part or all of vision.

2. Retrolental fibropiasia - an eye disease that caused blindness almost exclusively in premature babies due to too much oxygen.

3. Snellen Chart - a chart used to measure distant, central field acuity. It may be a standard letter chart or the symbol (E Chart) which is suitable for young children.

4. Visual acuity - visual keenness of perception.

5. Scotoma - a spot on the eye without vision.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

BLINDNESS FACT SHEET

1. Blindness is the partial or total loss of the ability to see.

2. There are two types of blindness:

   A. Congenital blindness - refers to people who are born with the defect.
   B. Acquired blindness - blindness caused by loss of sight through injury, accident or disease.

3. There are four principle kinds of blindness, in terms of how much can be seen:

   A. Total blindness - a person suffering from total blindness cannot tell light from dark.
   B. Economic blindness - a person that cannot see well enough to work for a living in any way that requires the use of the eyes.
   C. Vocational blindness - the loss of sight that prevents a person from continuing to earn a living in the same kind of work he has been doing.
   D. Educational blindness - the loss of the ability to see that interferes with a person's ability to get an education by the methods that are commonly used in school.

4. It has become traditional to define children with visual disabilities on a medical and psychological basis according to visual acuity and field of vision.

5. Legally blind children have central visual acuity of 20/200 or less in the better eye with glasses.

6. The number of visually impaired children requiring special education services are one in one thousand.

7. A research study found that the majority of legally blind students read print rather than braille.

8. Visual acuity is most often measured by the Snellen Chart.

9. The Bureau of Census, 1970, Statistics on Visually Handicapped, show the Illinois population to be 11,000,000. Of that number 22,700 are legally blind and 945 are school age (K-12). There are 52,300 visually impaired people who are unable to read print. There are 36,700 people who are visually impaired due to diabetes.

10. The 1976 Gallup Poll ranked disease and handicaps most feared in a cross country poll. Blindness was ranked as the second most feared by the American Public.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
DOG GUIDES FOR THE BLIND

I. First Dog Guides

A. World War I - 1923 - Germany (Ruecker and Wecherling).
B. 1929 - Dorothy Eustin - established first dog guide school in the United States.

II. The Master

A. Not every blind person is capable of using a dog guide. The following factors must be taken into account.

1. Physical condition - dogs move quickly (3-3½ miles an hour). They must be exercised, aired and used regularly. An elderly person or one in poor physical condition would not be capable of this.
2. Hearing - dogs are to take orders from their master ("Right", "Left", "Forward"). The master must know the direction in which he is going and be able to hear the motion of traffic and significant sounds of danger.
3. Vision - The master must rely on his dog. If he has any vision, this can be a potential problem. Dog guides are trained to lead - not to be led!
4. Intelligence - the master must have a required degree of intelligence to learn the methods of handling the dog and new routes to different destinations.
5. Emotional Stability and Temperment - the master must be able to cope with any difficult situations that arise and maintain control of the dog. People who are afraid or dislike dogs cannot have a guide dog.
6. Age Factor - dog users should be between 16 and 55 (there are a few exceptions based on individuals.) Young children do not have the maturity to handle a dog and people over 55 usually are not in the proper physical condition.
7. Motivation and Necessity - the master must desire to change his mode of travel. Generally these are the reasons:

   a. better job
   b. an increase of social activities
   c. the realization of a goal
   d. extensive traveling
   e. restricted mobility (problems in finding exact locations.

8. No dog guide is given to a mendicant or person with tendencies towards becoming a mendicant.
9. No one is ever turned away from a dog guide school for lack of funds.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

WHAT TO DO WHEN YOU SEE A BLIND PERSON -----

(AND WHAT YOU DON'T DO)

1. If you see a blind person who seems to need help, offer your services. Identify yourself and let him know you're talking to him. Otherwise, he might never know.
2. A blind person can cross the street without being pushed or pulled, so if he accepts your offer, let him take your arm. He can follow the motion of your body.
3. Go ahead and use words like "see" and "look". You can't avoid them anymore that a blind person can because there just aren't any reasonable substitutes.
4. Speak directly to a blind person, not through a third party. Interpretation is not necessary since blindness is not a separate language.
5. As tempting as it may be to pet a dog guide, remember that this dog is responsible for leading a master who cannot see. The dog should never be distracted from that duty.
6. When you're leaving a blind person, let him know you are. Don't leave him stranded.
7. And remember, when you do meet a blind person, common sense and sensitivity to others are most important of all.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
PHYSICAL HANDICAP OUTLINE

I. Historical Overview

  A. Early programs
    1. National Easter Seal Society
    2. United Cerebral Palsy Association
  B. Separate special schools
  C. Vocational Rehabilitation Act of 1973

II. Definition of physical handicap

III. Classification of physical handicap
  A. Neurologically related disability
    1. Cerebral palsy
    2. Spina bifida
  B. Musculoskeletal or orthopedic disability
    1. Muscular dystrophy
    2. Amputations
    3. Arthritis

IV. Architectural considerations
  A. Architectural Barrier Act of 1968
  B. Building barriers
  C. Classroom barriers

V. Medical considerations

VI. Personal adjustment

VII. Educational considerations
  A. Communication devices
  B. Reading aids
  C. Miscellaneous devices

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 1

Script: Physical Handicaps

by Alan Balter, P.h.D.
Assistant Coordinator

Today's topic is physical handicaps and I shall begin with a historical overview. Special classes and programs for crippled children were available in this country as early as 1900. Large cities including Chicago, Cleveland, and New York had early programs for orthopedically handicapped children who needed to attend school buildings with special architectural adaptations. Multiply handicapped children and children with single physical handicaps living in rural areas simply did not attend school early in this century.

Provision of a wide variety of services for the physically handicapped did not occur until the last twenty to thirty years. One organization which helped initiate and sustain many programs is the National Easter Seal Society for Crippled Children and Adults. This group along with the United Cerebral Palsy Association provided the impetus for the establishment of more numerous programs. Initial classes during the 1930s and 1940s were located in churches, private homes, or wherever space could be found. If a child's handicap were "simple", (that is, if the child were not multihandicapped) or if the handicap did not require much modification of the program, the child was sometimes admitted to public school classes.

During the 1950s, one of the popular methods of providing services to physically handicapped children was the separate special school. These schools became models of educational services for crippled children, with ramps and elevators, modified toilet areas and drinking fountains, therapy pools, and a full complement of adapted furniture and equipment. Certainly, much was learned from these schools particularly with regard to the kinds of architectural modifications required. However, segregating the child from his non-handicapped peers is considered a disadvantage of separate schools to the extent that today, with the exception of very severely physically handicapped children, attempts are made to integrate the child into his local public school program.

A very significant law which has led to increased public school responsibility for the physically handicapped is the Vocational Rehabilitation Act of 1973. Section 504 of this Act requires that all federally supported schools that employ more than fifteen persons must not discriminate on the basis of handicap. In other words, no handicapped person can be excluded from any program receiving federal assistance solely because of the handicap.

In summary, this century has seen tremendous growth of school programs for the physically handicapped. What started as a few isolated programs sponsored by parent organizations has become a national network of programs supported by the law. With this introduction, it is now necessary to define the population of children with whom we are concerned.

Children who are physically handicapped are defined as those with nonsensory physical disabilities that require the use of modified or adapted physical settings, curriculum presentation, or other specialized materials or equipment to permit maximal social and educational development. These children have a variety of physical impairments which interfere with the normal use of bones, muscles, or joints. Their impairments also may impede their ability to engage in important activities on an equal basis with children their own age. Progress through school, free movement in their environment and social adjustment with their peers are problem areas for children with physical handicaps.

Physical handicaps are very diverse. Some have pain associated with them; others do not. Some are progressive; others stable. Some have a gradual onset; others come on quickly. Because so many different problems are included under the label "physical handicap", it is necessary to classify these problems into sub-categories. The first category is neurologically related disability. Examples of specific disabilities in this category include cerebral palsy and spina bifida. Cerebral palsy is a very common physical disability. One can expect to find anywhere from one-third to one-half of the children enrolled in any program for the physically handicapped to be cerebral palsied. The simplest definition of cerebral palsy is a movement problem caused by damage to the brain. A more detailed definition is provided by the United Cerebral Palsy Research and Educational Foundation. Their definition includes the following elements: 1) caused by damage to the brain, 2) motor disturbance, including paralysis, weakness, and incoordination, 3) usually originates during childhood, 4) often includes learning difficulties, sensory deficits, and/or behavior disorders. Indeed, cerebral palsy is a complex problem. While it is true that children with cerebral palsy may be very bright, more often mental retardation is present. Very often speech defects are present and there will always be some impairment of movement. Children with cerebral palsy are usually classified as multihandicapped.

Several different types of cerebral palsy have been identified. The most common variety is spastic cerebral palsy. Movement is spasmodic and jerky whenever the child attempts to initiate voluntary movements. Spasticity may affect any or all limbs. Athetoid cerebral palsy is the second most common type. Here the movements are slower, more twisting and serpentine.

The head is often drawn back with the neck extended and the mouth open. There is more purposeless movement and facial grimaces are more common than in spasticity. Ataxia, tremor, and rigid are other varieties of cerebral palsy. Ataxia includes balance problems and incoordination of the eyes. Falling is a common result. Tremor usually includes involuntary vibration of the entire body, while rigidity involves a somewhat rigid posture with diminished movement. Ataxia, tremor, and rigid types are less common and less likely to be diagnosed at birth compared to the spastic and athetoid types.

In addition to describing cerebral palsy by its type. It may also be described by the parts of the body affected. Thus, monoplegia refers to an affect upon one limb, hemiplegia to half the body, paraplegia refers to the legs being affected, and quadriplegia to all four limbs. A full description of cerebral palsy includes the type, part of the body affected, degree of involvement (mild, moderate, severe) and associated disabilities.

A second example of a neurologically related disability is spina bifida. This is a birth defect in which the bony casing protecting the spinal nerves failed to close during fetal development. This causes the spinal nerves to be exposed and subject to damage. In its more serious form, a cyst or sac is visibile on the lower portion of the back. This protrusion is usually treated surgically soon after birth. The extent of disability resulting from spina bifida varies tremendously. Some children will have little or no disability while others have varying degrees of paralysis of the legs or may be unable to control their bowels or bladders. There are surgical procedures that can assist with bladder control or the child may wear an artificial device to collect the urine. It is important to recognize how crucial it is for the teacher to work in close harmony with medical personnel and especially the school nurse to insure proper care for the spina bifida child.

A second sub-category of physical handicap is musculoskeletal or orthopedic handicap. Examples of specific physical handicaps in this category are muscular dystrophy, amputations, and arthritis.

Muscular dystrophy is a progressive, hereditary disease in which muscle fibers degenerate and are replaced by fatty tissue. The most common and most serious type, Duchenne, occurs in children and is generally considered fatal. The age of onset is between one and six years and seldom occurs after age ten. Early signs include a tendency to fall, clumsiness in walking, and difficulty in climbing stairs. There is a steady decline in the child's ability to walk. As he continues to lose strength, he moves to a wheelchair and then is bedridden. Naturally as the disease progresses, so does the need for adaptation in the child's school program. It is recommended that the child be kept in school as long as possible and then be provided with homebound instruction.

Amputations are another example of orthopedic disability. An amputation may be congential, acquired as a result of trauma, or elective as a result of disease or infection. In most instances, the child will be fitted with an artificial arm or leg called a prosthesis. The prosthesis may be made of wood, metal, or plastic with plastic being the most common due to its light weight.

The extent of any necessary modifications in educational program for an amputee will depend on the age of the child, the site of the amputation, and the manner in which the child has adjusted to the disability. In general, the higher the amputation, the more severe the educational disability. A child with a missing leg but with a properly fitted prosthesis requires less special programming than a child with a missing arm. Proper amounts of exercise, attention to postural habits, and modifications in equipment such as pencil holders and page turners are important considerations for children with amputations.

The most common form of arthritis in children is called juvenile rheumatoid arthritis. The onset may be very sudden or slow and gradual. In some cases it lasts only a few weeks or months, but in others it is chronic, gradually worsening as the child gets older.

Rheumatoid arthritis attacks the joints of the body and may also involve the heart, liver, and spleen. As the disease progresses, the joints may stiffen making movement very difficult and painful. Treatment for arthritis is highly individualized because no two cases are the same. Generally, aspirin is the single most effective drug because it reduces pain and inflammation of the joints and is relatively safe. Physical thereapy and heat treatments are often part of the prescription. Sometimes surgery is required to correct deformity caused by the disease.

Specific types of physical handicaps have been described. These should not be considered a total listing but rather representative examples of neurologically and orthopedically based physical handicaps.

To provide adequate educational programs for physically handicapped students it is first necessary to have school buildings and classrooms which are architecturally accessible to the students. The Architectural Barrier Act of 1968 (Public Law 90-480) mandates that any building receiving federal funds (this includes schools) must make efforts to eliminate architectural barriers and promote unrestricted accessibility. Below is a listing of the kinds of barriers faced by physically handicapped students around their schools and classrooms:

A. School building barriers
  1. Parking stalls too narrow to allow wheelchair exit and entrance to cars
  2. Curbs too high to gain access to sidewalks
  3. Building entrance via stairs with no ramps
  4. Entry doors too heavy to open from seated position
  5. Entry doors too narrow to accomodate wheelchairs
  6. Restrooms not equipped with low stools, sinks, mirrors and towels
  7. Halls with no handrails

B. Classroom barriers
  1. No handrails on walls to allow movement around class
  2. Desks too low for students in wheelchairs
  3. Aisles too narrow to accomodate wheelchairs or students on crutches
  4. Classroom doors too heavy
  5. Chalkboard placement too high to allow student to do boardwork.

Teachers who are aware of these accessibility needs and who are concerned with facilitating the school adjustment of physically hanciapped students must make suggestions to the administration on the elemination of such barriers.

Another necessity in providing adequate school programs for physically handicapped students is the requirement of understanding medical implications of disabling conditions. The teacher needs to have full access to the child's medical records and should be encouraged to confer with the school nurse and the child's physician. Obviously, total cooperation between teacher, parents, nurse, and doctor is a must.

Medical considerations important for the teacher include knowing any medication prescribed and possible side effects that could interfere with classroom work. Poor bladder and bowel control will demand special toileting considerations. Physical stamina can be limited by certain physical problems which necessitate that the child be provided with several rest periods during the day. Also, teachers need to be familiar with the use and maintenance of appliances such as canes, wheelchairs, braces, and crutches. Knowledge of available tutors or homebound teachers may be required due to frequent absence. Scheduling may have to be flexible because of the necessity of physical therapy sessions. Finally, arranging for transportation from one class to another will have to be coordinated by the teacher. All of the above are special considerations relating to medical factors . Teachers also need to be concerned about the physically handicapped child's personal adjustment.

Children who have physical handicaps have suffered a loss. Consequently, they often proceed through a grieving process similar to that which others feel when confronted with a personal loss. This grieving process involves five stages: denial, anger, bargaining, depression, and finally acceptance. Teachers can better understand the handicapped student if they first understand that progress through these stages to ultimate acceptance is not always smooth or rapid. Students cannot be forced through them, but should be allowed to progress at their own rate. In denial, the child attempts to ignore the loss and engage in activities enjoyed before the loss even though the disability prohibits involvement. The anger stage is a "why me?" period. The child is aggressive and hostile to other children and adults including the teacher. In bargaining, the student attempts to substitute behaviors. The child is essentially saying, "If you or I do this, things will get better and the problem will go away." Bargaining involves unrealistic solutions to the problem. In depression, the child withdraws and hides feelings. There is a good deal of self pity and isolation. Finally, in acceptance, the child fully realizes the extent of the problem and the limitations it imposes. The child will now openly discuss the disability and operates effectively within its limits.

The above stages give teachers a way to understand the adjustment problems a physical handicap imposes. The teachers job is to work with other professionals and parents to try and help the child move as rapidly as possible to the acceptance stage.

The educational content presented to the physically handicapped child in the regular classroom is the same as that presented to the non-disabled student. What differs is the mode of presentation or the instructional techniques used. Below are lists of specialized instructional aids that can be used.

A. Communication devices
   1. manual typewriter
   2. electric typewriter
   3. one-handed typewriter
   4. tape recorders
   5. manual or electric communication board
   6. writing harness; pencil holder that fits hand
   7. magnetized wrist harness; to hold hand to metal tray or table to write.
   8. one-handed writing board with clips
   9. metal writing frame to attach to wheelchair

B. Reading aids
   1. talking book machines
   2. large print books
   3. magnifying glasses
   4. special book holders to hook to wheelchair
   5. automatic page turners
   6. specially designed tables; cut-out for wheelchair or standing table for support

C. Miscellaneous devices
   1. double handed scissors
   2. electric scissors
   3. lap trays for wheelchair
   4. large tongs for reaching
   5. mouth stick for pointing or typing
   6. head pointer with harness for page turning or typing

B

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
PHYSICAL HANDICAP VOCABULARY LIST

1. Amputation-the loss or absence of a body limb.

2. Arthritis - a disease affecting the joints resulting in pain and inflamation.

3. Ataxia - one type of cerebral palsy characteized by unsteady balance and gait and lack of coordination of eyes.

4. Athetosis - one type of cerebral palsy characterized by twisting movements and facial grimaces.

5. Cerebral palsy - a complex condition characterized by motor problems and caused by injury to the brain.

6. Duchenne muscular dystrophy - a hereditary disease, generally fatal, involving destruction of muscles.

7. Monoplegia, hemiplegia, paraplegia, quadraplegia, triplegia - terms used to describe the extent of body involvement in cerebral palsy.

8. Multihandicapped - any combination of two or more handicaps.

9. Musculoskeletal - a category of physical handicap including conditions affecting the muscles, bones, or joints.

10. Neurological disability - a category of physical handicap including conditions affecting the central nervous system.

11. Orthopedic handicap - a term synonymous with musculoskeletal or crippling condition.

12. Prosthesis - an artificial body part.

13. Spina Bifida - a birth defect resulting from damage to the spinal nerves often accompanied by paralysis of the legs and bowel and bladder problems.

14. Spastic - one type of cerebral palsy characterized by abrupt jerky movement.

15. Tremor and Rigid - categories of cerebral palsy.

B

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

PHYSICAL HANDICAP FACT SHEET

1. Programs for the physically handicapped in school did not become common until the last 20 to 30 years.

2. Two organizations which have helped in the development of services for the physically handicapped are the National Easter Seal Society and the United Cerebral Palsy Association.

3. Children who are physically handicapped are defined as those with nonsensory physical disabilities that require the use of modified or adapted physical settings, curriculum presentation, or other specialized materials or equipment to permit maximal social and educational development.

4. Physical handicaps can be classified in categories such as neurologically related disabilities and musculoskeletel or orthopedic disabilities.

5. Examples of neurological related disabilities are cerebral palsy and spina bifida; examples of musculoskeletal or orthopedic handicaps are muscular dystrophy, amputations, and arthritis.

6. Cerebral palsy is the most common physical handicap. It involves motor disability caused by damage to the brain. Different types have been identified. These are called spasticity, athetosis, ataxia, tremor, and rigid.

7. Adequate school programs for the physically handicapped require architectural modifications to both the school building and the classroom.

8. Teachers working with the physically handicapped must participate as members of multidisciplinary teams. Particularly important is their understanding of medical considerations relating to physical handicap.

9. Physical handicap is perceived as a loss for the child which makes personal adjustment difficult. A grieving process is involved which requires passage through five stages prior to healthy adjustment to the loss. These stages are denial, aggression, bargaining, depression, and acceptance.

10. Educational considerations for the physically handicapped requires that classrooms be equipped with many special devices. Communication devices, reading aids, and miscellaneous devices are needed. Examples include talking books and typewriters, automatic page turners, and two handed scissors.

11. Two laws which have helped in the development of more adequate programs for the physically handicapped are the Vocational Rehabilitation Act of 1973 and the Architectural Barriers Act of 1968.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
PHYSICAL HANDICAP REFERENCE SHEET

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MASLOW'S HIERARCHY OF NEEDS

by LaVerne H. Galzin, R.N.

In Maslow's theory, individuals are constantly striving to fulfill their basic needs. Maslow has suggested that there are five basic categories of human needs. The lower level needs must be satisfied (at least in part) before the individual attempts to satisfy needs of a higher order. The basic types of needs in order of priority are:

1. Physiological needs
2. Safety and security needs
3. Needs for love and belonging
4. Esteem needs
5. Needs for self-actualizations

Physiological needs take precedence over all others because they are essential for survival. For example a person who is starving has a life which revolves around obtaining sufficient food. The fulfillment of certain of these basic needs is so essential that if there is interference with attainment of them, immediate action must be taken in order to save the person's life. If there is interference with breathing and a person's air supply is cut off, prompt measures must be taken to restore adequate respiration or the person will die within a matter of minutes.

In secondary priority are the safety and security needs. This includes such fundamental needs as adequate shelter and protection from harmful factors in the environment. Many times children have a favorite toy or another object they usually like to take with them wherever they go. This helps to provide a feeling of security when they are in a strange or unfamiliar surrounding.

Maslow places the needs for love and belonging as the third most important in this hierarchy. Infants deprived of love and affection do not thrive, even if all their physiological and safety needs are met. Adults, too, need to have people who are close to them, to share their joys, sorrows, anxieties and doubts. People who do not have close ties with other people often have pets which they lavish with their love and affection.

Esteem needs are fourth in Maslow's hierarchy. People must feel that they are worthwhile as human beings. They must feel they are considered as an individual of worth and dignity, by their family and by others with whom they come in contact.

Maslow has suggested that many of the problems of people in our impersonalized society, particularly in the big cities, are due to failure to satisfy the basic needs of love, belonging and esteem. If people do not have these needs satisfied, they come to have a low regard for themselves and feelings of inadequacy, frustration, alienation and hopelessness result.

The last step of the hierarchy are needs for self-actualizations. These include the need to attain one's highest potential and to achieve one's ambitions in life. This also includes the need for knowledge and the aesthetic needs for something beautiful in one's life.

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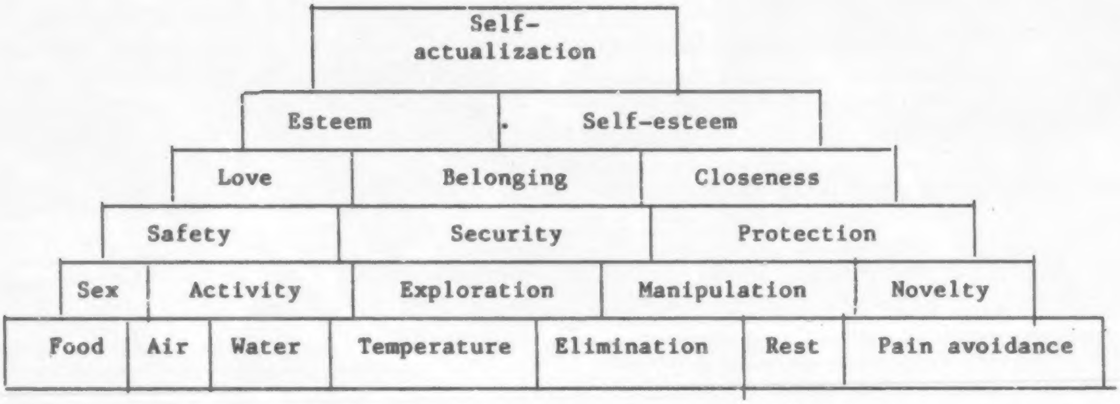
PROJECT: C.H.A.N.G.E.
TITLE IV C
MASLOW'S HIERARCHY OF NEEDS
ADAPTED BY KALISH


Self-actualization
Esteem
Self-esteem
Love
Belonging
Closeness
Safety
Security
Protection
Sex
Activity
Exploration
Manipulation
Novelty
Food
Air
Water
Temperature
Elimination
Rest
Pain avoidance

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B

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
DIABETES MELLITUS OUTLINE

I. A Historical Overview

- a. A disease almost as old as man
- b. Roman Era saw the first scientific study of diabetes
- c. In 1921 insulin discovered
- d. In 1956 oral hypoglycemic agents used

II. Incidence

- a. Five per cent of world population has diabetes mellitus
- b. Five per cent of U.S. population has diabetes
- c. Incidence appears to be increasing 6% per year
- d. Average American born today has better than 1 in 5 chance of developing Diabetes

III. Statistics

- a. Slight preference for women and middle aged persons
- b. More prevalent in Northeastern States

IV. Predisposing Factors

- a. Heredity
- b. Obesity - Middle age
- c. Sedentary, inactive lives

V. Types of diabetes

- a. Insulin dependent diabetics
    1. Juvenile (always) need injectable insulin
    2. Mature onset (sometimes) needs injectable insulin
    3. Stress Diabetes (Sometimes need injectable insulin

VI. Types of Management for Diabetes

- a. Injectable insulin, controlled diet & exercise, and need supervision
- b. Oral Hypoglycemics, controlled diet & exercise, and need supervision
- c. Controlled diet, exercise, and medical supervision

VII. Testing of urine

- a. For sugar
- b. For ketones

VIII. Complications of diabetes

- a. Cataracts, retinopathy, blindness
- b. Cardiovascular diseases
- c. Kidney failure
- d. Neuropathies of bladder, eyes, gastro-intestional tract, hands, feet, and reproductive diseases
- e. Periodontal disease
- f. Amputation of limbs
- g. Skin infections and lesions

IX. Research and the Future

a. Transplants
b. Cause of the disease
c. More effective way of administering insulin
d. More effective way to keep a constant balance in a diabetic at all times

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session #2

Script: Diabetes

by
LaVerne Galzin, R. N.
Medical Consultant

Diabetes Mellitus - A chronic, or long term, disease resulting from the body's inability to use certain basic elements of everyday food, especially starches and sugars. Often the pancreas fails to produce enough of the hormone insulin, and abnormal amounts of sugar accumulate in the blood and the urine. If untreated, this condition can have serious consequences. Poisons in the blood bombard the brain, producing coma and ultimately death. Although diabetes cannot be cured, it can be effectively controlled by close medical supervision, proper diet, exercise, and/or medication.

Diabetes is a disease characterized by abnormalities of the endocrine secretions of the pancreas resulting in disordered metabolism of carbohydrates, fats, and protein and, in time, structural abnormalities in a variety of tissues.

Diabetes is as old as man. Early descriptions tell of a mysterious disease which killed people in their prime. This disease could not have been heart disease or cancer, since primitive man would have considered these afflictions of old age. Now could it have been obvious killers such as infections diseases or plague since these strike quickly and leave signs. We know now that this mysterious disease was diabetes.

It was during the Roman Era that Diabetes was first named and studied. The word "diabetes" means to pass through. It was so named, because the Roman physicians thought the frequent urination associated with diabetes was due to weak kidneys. The first descriptions of the disease and subsequent interest in it ended as the Roman Era did. For the several centuries of the dark ages no further progress on the disease was made.

Prior to the Renaissance, the healing arts degenerated into guesswork. Physicians could only surmise about the interior of the human body, since autopsy and dissection were expressly prohibited by ecclesiastical fiat. The sciences of anatomy and pathology were mysteries awaiting to be unraveled.

During the Renaissance man began to push back the wall of ignorance. But many centuries had passed between the fall of Rome and Leonardo DeVinci's first anatomical drawings. It wasn't until the seventeenth century that a significant breakthrough was achieved when an Oxford Physician named, Willis, demonstrated that diabetes is accompanied by sugar in the urine.

From this point until the twentieth century the study of diabetes proceeded at an unspectacular but steady pace. Watching helplessly as their patients wasted slowly or died suddenly, physicians guessed that some defect in the pancreas prevented the proper chemical breakdown of sugar, permitting it instead to accumulate in the blood. They knew that death resulted from kidney failure or coma but they knew no herb or drug capable of reversing the disease once it had started. By the dawn of the twentieth century scientists suspected that diabetes was probably hereditary rather than infectious, that it very likely flourished in the same families, and was not spread by germs.

In 1921, Dr. Frederick G. Banting and Dr. Charles Best discovered that an extract from a dog's pancreas eliminated sugar from the urine and lowered blood sugar level when injected into a diabetic dog. This extract, which they named insulin, was studied for several months before Banting and Best announced their discovery the following year. Publicity about the new "cure" for diabetes brought requests from all over the world - even before it had been tried on humans.

During the next twenty years, physicians realized that while insulin was invaluable in keeping many diabetics alive, it seemed to have an adverse effect on other patients. At first it was thought that some diabetics were allergic to insulin, just as some people today are allergic to certain antibiotics. It became apparent that insulin was actually speeding up complications in some diabetics.

The belief that insulin was only a partial answer to diabetes led to the development, by Dr. Auguste Loubatieres in France in 1942, of oral drugs which lowered blood sugar levels and did not have adverse side effects. These drugs, called the oral hypoglycemic agents (any medicine that when swallowed lowers the amount of sugar in the blood), did not join insulin as a control for diabetes until 1956.

Thus, while oral hypoglycemic agents liberated many diabetics from the annoyances of daily insulin injections, insulin therapy was clearly indicated for others. THERE IS NO ONE TREATMENT FOR DIABETES, anymore than a one-size suit or a one-size hat would fit all people. The fact that it is possible to treat some forms of diabetes by pills rather than injection often confuses people. Many times when a patient is told he must inject insulin every day he is likely to think that his doctor hasn't heard of the pills yet. This response is a common result of inadequate knowledge about the disease and its management.

Fortunately, the majority of the diabetic population today can be helped by pills. This group usually includes those who have developed the disease after reaching maturity (and usually middle age). Those who contract it during childhood or teens usually require insulin for the remainder of their lives.

But regardless of whether an injection or a pill is used to control diabetes both are superior to the misery and disability which were the plight of the diabetic before 1921. A delicate balance of (1) medication (if indicated), (2) proper adherence to dietary restrictions, (3) exercise, and (4) medical supervision by the family physician are the primary requirements for many, but NOT FOR ALL, to lead a normal, comfortable life.

Approximately 5% of the world's population has diabetes mellitus. About 5% of the U.S. population has diabetes; the incidence appears to be increasing by 6% per year. The average American born today has better than a one in five chance of developing diabetes. One-half of all patients have a known relative with the disease. Diabetes is a democratic disease. It does not discriminate by age, nationality, race, or physique. Diabetes may strike immediately after birth, or it can linger until middle age, or even later. Statistics show that today diabetes shows a slight preference for women, and middle-aged persons. In the U.S., the disease is most prevalent in the Northeastern states. If middle-aged people are overweight the chances of their contracting diabetes are greatly enhanced.

One of the strongest predispositions is a family history of diabetes. Diabetes occurs five times more often among those with a family history of the disease than among those with no afflicted relatives. Another dangerous predisposition is obesity. Four out of five diabetics are overweight before manifesting actual symptoms of diabetes. Obesity is considered by many investigators to be second only to heredity as the most responsible factor in development of the disease. Although diabetes is seen in all age groups, and it is most critical in childhood, it is ten times more common in patients over 40 than it is in those under 20. Like heart diseases, diabetes is much more common among sedentary, inactive people than among those who lead vigorous lives.

Diet: There are two distinct types of diet - one to lower weight by restricting caloric intake and the other to control metabolism by regulating amounts of food. The diabetic must adhere to the second diet at all times. A diabetic diet must accomplish many purposes, the most important of which is compensating for basic flaws in the metabolism - the process by which the body digests, dissolves and simplifies food, transforming it into human tissue and energy.

To better understand the relationship of diet and diabetes a brief review of what happens to food once it is swallowed is in order. The body requires three elements from foods - carbohydrates for heat and energy, protein for forming blood and muscle tissue, and fat to protect and cover the vital organs.

Carbohydrates, which are of maximum concern to the diabetic, come from sugar and starches (potatoes, bread, etc). These foods are broken down into glucose which in turn supplies the cells of the body with fuel for heat and energy. The body relies on carbohydrates as its chief source of fuel.

Protein is provided by meat, eggs, and dairy products. Although it is essential to life, protein is usually no problem in the diet as long as the diabetic gets a sufficient amount.

Fats, which also must be closely watched by the diabetic, come from such foods as butter, bacon, milk, cream, etc.

(Overhead #1) Metabolism in Diabetes - The pancreas, one of the glands of the endocrine system, is a three to four inch gland shaped like a triangle. The islets of Langerhans, mainly the beta cells, located in the pancreas produce the body's insulin which drains directly into the blood. In the diabetic the primary problem is a deficiency in insulin secretion.

Foods and liquids are processed and broken down into fats, proteins, and carbohydrates while in the stomach. The pancreas is supposed to secrete enough active insulin to burn up carbohydrates or store them. When the pancreas doesn't secrete enough active insulin, the sugar or glucose form of carbohydrate increases excessively in the blood, overflows and passes through the kidneys into the urine. This is why the diabetic tests his urine daily. Urine testing will be discussed again later in the lecture. Normally, glucose enters the bloodstream as a source of fuel for the various organs in the body. When glucose is not used correctly the organs are deprived of energy resulting in many complications.

When a pancreas is defective and no insulin is produced the result is insulin-dependent diabetes. The excess sugar in the blood must be controlled either by injecting insulin directly or by taking oral drugs which stimulate the insulin-producing beta cells of the islets of Langerhans of the pancreas to supply enough of the hormone and by control of intake by diet in conjunction with exercise. Too much sugar is equally as harmful as too little sugar. If, on the other hand, excess insulin is produced too much energy-bearing sugar is burned up resulting in a condition known as hypoglycemia.

There are different types of diabetes. Type A - The insulin dependent diabetic or juvenile onset diabetic. The one most people think of then they hear the name of the disease. Only 15% of all diabetics fall into this category, but it is the most dangerous of the three types and must be diagnosed, treated, and watched carefully. Type A diabetics or insulin-dependent diabetics are usually children or young adults but sometimes an older adult may also get this type. It is the most severe form of the disease. Insulin is as much a part of Type A diabetics' lives as their daily shower.

Insulin injections are essential since their pancreas DOES NOT PRODUCE ANY OF THIS VITAL HORMONE. For this type of diabetic this is the only means of therapy plus a controlled diet and exercise. Because its hallmark is a total lack of insulin, it comes with stunning swiftness, and a child may go into diabetic coma - sometimes the first clue to the child's disease. Insulin cannot be given orally because it is a protein and would be digested, just like meat, by enzymes in the digestive tract. Although various methods have been tried, at the present time, the only way to get insulin into the body past the chemical barrier which destroys it, is by direct injection.

There are three types of insulin: quick acting, intermediate, and prolonged acting. Insulin-dependent diabetics are usually controlled on one daily injection of insulin; either the intermediate or prolonged acting type. But insulin-dependent diabetics have their own regimen and may require a second injection of quick acting insulin, depending on their urine checks, activities, and diet.

The patient's failure to follow a diet, the failure of the digestive system to dispose properly of the food eaten, overexertion, or too small or too large a dose of insulin can all produce reactions in the diabetic. Insulin reactions will occur according to a chemical timetable determined by the type of insulin used. Reactions to intermediate insulins can occur from eight to twenty hours after injections. Some patients rarely experience insulin reactions. Although a mild reaction can terrify the uninformed patient, family, or friends, a preventive measure is recognition of the early warning symptoms which precede a reaction. Onset is sudden, increased hunger, faintness, or a cold sweat occur.

Type B - Overweight or maturity-onset Diabetes - (Overhead #3) This type of diabetes is usually less severe. Eighty per cent of the people who have diabetes have this type. It is not due to an insulin deficiency, but rather to anti-insulin factors which prevent the insulin from being active. This type of diabetes can usually be controlled with oral drugs and/or a balance of diet and exercise.

Type AB - Stress Diabetes - Stress diabetes is the newest form of diabetes. It is called diabetes because the patient can normally be controlled with oral drugs or small doses of insulin, but physical or emotional stress will sharply increase their blood sugar. Stress diabetes first appears in men and women in their thirties or forties who are either underweight or of normal weight. During times of stess, infections, surgery, or emotional crises, the type AB patients must be transferred from oral therapy to insulin injections or if they are already on insulin, their insulin requirements must be increased.

Occasionally prolonged stress will turn an AB stress diabetic into a Type A insulin-dependent diabetic. These people develop a true insulin deficiency and need insulin the rest of their lives.

There are four types of urine tests. (Only one type will be discussed). The need for testing depends on the nature of the diabetes. Very mild diabetics or borderline diabetics usually do not need to test their urine daily.

Average adult diabetics taking insulin should test their urine for sugar each morning before breakfast. This is a guide to the adequacy of the insulin dose. Juvenile diabetics usually check their urine three times per day or more, once before breakfast, lunch, and dinner, and sometimes before bedtime.

There are several easy ways to test the urine. One test is called the Clinitest. The kit contains a test tube, a dropper, and some tablets. Urine is collected in a small plastic or paper cup. Two drops of urine are placed in the test tube and ten drops of water are added. One tablet is dropped in the test tube. For approximately 15 - 20 seconds, the mixture bubbles. When the bubbling stops the urine and water have changed color. The color is compared to a color chart enclosed in the kit: blue - no sugar is present; green - the amount of sugar is slight; yellow - about 1% sugar is present; orange - indicates more than one per cent; and orange-red shows more than two per cent. At the same time diabetics tests for glucose , they also test for ketones. This is another type of test and is also graded on a color chart. Ketones occur when the body is not using fats and proteins properly. Carbohydrates are used by the body as its chief fuel when insulin converts them into glucose. Lacking enough insulin though, the body will begin to rely on fats as its chief fuel. As by-products of this fat metabolism, fats produce ketones. Results of the urine and ketone tests help the doctor determine how well the diabetic is being controlled.

(Overhead #4) Complications of diabetes include: cataracts, cardiovascular disease, kidney failure, neuropathies of the bladder, eyes, gastro-intestinal tract, hands and feet, and reproductive system; vascular disorders resulting in diminished circulation especially in the feet causing a very slow hearling process in diabetics. A small cut, or an infected toe, may lead to an ulcer which could lead to gangrene and an amputation of a limb. Retinopathy (Irreversible damage to the retina of the eye) resulting in blindness; skin lesions and infections - sounds like an excerpt from an index of diseases. It is not. It is a list of SOME of the complications of diabetes mellitus.

Research and the Future - The etiology or cause of diabetes is still unknown. There are several theories that are being investigated and researched at the present time. One is that diabetes may be caused by a virus. Another theory is that diabetes may be triggered by an infectious process in persons who are genetically predisposed to the disease. Chemists, biologists, and other medical researchers are accelerating their efforts in research centers throughout the world to explore a multitude of leads that may eventually result in unmasking the origin of this disease.

The multitude of diabetes research continues to make meaningful and useful contributions to existing knowledge.

The American Diabetes Association has special I.D. bracelets and I.D. cards which are made available for the diabetic. Local hospitals have classes available for the diabetic. Probably there is no other disease in which it is as important that the individual be taught all the factors involved in the management and treatment of their disease.

A combination of all these factors is contributing to a longer and more normal life for the diabetic. In conclusion, we will discuss some diabetic reactions which can result from improper treatment. (Read the information on Overhead #5).

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

DIABETES MELLITUS VOCABULARY LIST

Diabetes Mellitus:	A disease characterized by abnormalities of the endocrine secretions of the pancreas resulting in disordered metabolism of carbohydrates, fats, and protein, and in time, structual abnormalities in a variety of tissues.
Insulin:	A. A hormone secreted by the beta cells of the islet of Langerhans of the pancreas. B. A preparation used in the medical treatment of diabetes and obtained from an animal pancreas (Usually pork or beef). This is not a cure and not necessary for every diabetic.
Glucose:	A simple form of sugar used by the body.
Pancreas:	One of the glands of the endocrine system. It contains the islets of Langerhans.
Metabolism:	Includes all processes involved in utilization of substances entering the body.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

DIABETES MELLITUS FACT SHEET

1. Diabetes Mellitus is a disease characterized by abnormalities of the endocrine secretions of the pancreas resulting in a disordered metabolism of carbohydrates, fats, and protein and, in time, structural abnormalities in a variety of tissues.

2. A. Insulin is a hormone secreted by the beta cells of the islets of Langerhans of the pancreas. It is essential for the proper metabolism of blood sugar and for the maintenance of the proper blood sugar level.

   B. A preparation used in medical treatment of diabetes. It is prepared from animal pancreas, usually pork or beef. It is not a cure, and it is NOT necessary for every diabetic.

3. Insulin preparations are divided into three categories according to how quickly they act, their potency, and duration following administration. The three types are fast, intermediate, and long lasting.

4. An oral hypoglycemic agent is NOT oral insulin. It is an agent which when swallowed lowers the amount of sugar in the blood.

5. Insulin cannot be taken orally because it is a protein and would be digested by the enzymes in the digestive tract.

6. Diabetic Coma, or acidosis, is due to an acute insulin deficiency. This can cause an excess of fatty acids in the body (acidosis) and lead to coma and sometimes death.

7. Insulin shock, or an insulin reaction, occurs when the level of the blood sugar is below normal due to too much insulin, too little food, or over-exercise in a diabetic. It occurs most often in those who take injectable insulin and occasionally in those who take oral hypoglycemics (oral medication).

8. Juvenile onset diabetes is considered the most severe form of diabetes because it is the most difficult to regulate. It always requires injectable insulin in conjunction with a controlled diet, exercise, and medical supervision. It shortens life expectancy, and because diabetes is a chronic long-term disease, it can cause many other complications.

9. There are many factors which may be considered predisposing causes for the disease. Heredity, middle age, overweight, and leading an inactive, sedentary life are just a few. Women may be more prone to diabetes than men.

10. The exact etiology, or cause, of diabetes mellitus is still unknown.

11. There are many complications of diabetes. Heart trouble, blindness, gum disorders, foot disorders, gangrene, kidney failure, are just a few.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MENTAL RETARDATION OUTLINE

I. Historical Overview

    A. Eighteenth Century
    B. Nineteenth Century
    C. Twentieth Century

II. Definition

III. Diagnostic Classification

    A. Mild Mental Retardation
    B. Moderate Mental Retardation
    C. Severe Mental Retardation
    D. Profound Mental Retardation

IV. Characteristics

V. Incidence and Causes

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 3

Script: Mental Retardation

by
Karen Harper
Primary Curriculum Advisor

In the Eighteenth Century, public interest in the problems of mental retardation was raised by Jean Itard's attempt to educate the Wild Boy of Aveyron. Several schools were subsequently started in Europe based on the theory that mental retardation was amenable to education. During the Nineteenth Century many misconceptions were formed concerning mental retardation (mental retardation is a disease, delinquent and criminal behavior are a consequence of mental retardation, etc.). Because of this very little progress was made in the area of education of the mentally retarded. In the early part of the Twentieth Century, some attempts at differentiation in the segregation and treatment of the mentally retarded began to appear. The development of the intelligence test in the early 1900's contributed to this. As the century passed understanding of the concepts of mental retardation increased, and more specialized provisions were made for training mentally retarded persons, particularly in the public schools. Three major eras in work with mentally retarded children have been identified.

The first period from 1850 to 1900 was characterized by the development of institutions. The second period from 1900 to 1950 stressed day-school special classes. The third period from 1950 to the present has emphasized considerable expansion of research and experimentation with new forms of education and treatment.

The American Association on Mental Deficiency defined mental retardation as: (Overhead #1) "(Mental retardation is characterized by) significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." It is extremely important in making a diagnosis of mental retardation that the intelligence quotient should not be the only criterion used. It should serve only to help in making a clinical judgement of the individual's adaptive behavioral capacity. The judgement should also be based on an evaluation of the individual's developmental history and present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

The diagnostic classification of mental retardation is based on I.Q.

Mild Mental Retardation	I.Q.	52-67
Moderate Mental Retardation	I.Q.	36-51
Severe Mental Retardation	I.Q.	20-35
Profound Mental Retardation	I.Q.	Under 20

Children in the mild range can profit from a simplified school curriculum and can make an adequate through modest social adjustment. Children in the severe range need institutional or some type of custodial care.

Most retarded children have many of the following characteristics although it is important to remember that each child, even though retarded, is a unique individual and must be regarded as such and not stereotyped.

A. Delayed achievement of developmental skills such as sitting, walking, feeding, talking and dressing.
B. Problems in gross motor and fine motor co-ordination.
C. Language disabilities and speech impairments.
D. Poor performance on verbal and nonverbal tests of intelligence.
E. Difficulty in concept formation - they can deal with concrete materials but have difficulty working with abstractions (Overhead #2)
F. Short attention span (Overhead #3)
G. Poor short-term memory skills (Overhead #4)
H. Perseveration - rigid approach to problem solving.
I. Trouble generalizing
J. Social Immaturity (Overhead #5)

Three percent of the general population are mentally retarded. The known types of etiological factors that directly contribute to mental retardation include: Prenatal or postnatal infection, cerebral damage due to toxic agents, brain injury due to trauma or mechanical or physical agents, injury due to metabolic, nutritional, or growth dysfunctions, damage due to new growths in the brain, structural damage to the brain with unknown causes, and genetic factors. Severe or profound retardation is usually the result of genetic factors or severe physical trauma or disease.

The most frequently encountered specific types of severe mental retardation are:

1. Down's Syndrome (Mongolism)

   a. Physical Characteristics
   Almond-shaped slanting eyes, deep transverse fissure in the tongue, an absence of definite patterns in the lines of the palm of the hand, close-set, deep eyes which are often crossed, flattening of the bridge of the nose, a flaccidity of the muscles, thick stubby hands, very small fingers, short stature, subnormal weight, and lax bone joints.

b. Mental Abilities:
Usually within the trainable range (I.Q. 30-50) although may have intellectual capacities at higher or lower levels - environment may influence.

c. Etiology:
Chromosomal abnormalities.

d. Incidence:
10% of all institutionalized individuals.

2. Cretinism

a. Etiology:
Insufficient secretion of the thyroid glands.

b. Physical Characteristics:
Small stature (dwarfism); short thick legs; dispreportionately large head; short broad hands; dry coarse skin; large and protruding tongue; short, thick neck.

c. Mental abilities:
Wide-range; if untreated becomes progressively worse - if medical treatment is initiated at early age mental capacity may reach an average level.

d. Incidence:
5% or less of institutionalized individuals.

3. Microcephaly:

a. Physical characteristics:
Inadequate growth of the brain; disproportionately small head of conical shape, with a receding forehead and flattened back part.

b. Mental ability:
Usually in the range of sub-trainable (0-30) or low range of trainable (30-50).

c. Etiology:
Primary form is thought to be the result of a recessive gene; secondary form is related to prenatal abnormalities such as excessive radiation, inadequate oxygen supply, and infections in the mother.

d. Incidence:
One percent of institutionalized individuals.

4. Hydrocephaly:

a. Physical Characteristics:
Unusually large head due to the accumulation of excessive cerebrospinal fluid within the skull. In severe cases, the bodies of such children are very slight, and their necks cannot support the excessive weight of their heads.

b. Mental Abilities:
Usually in the range of severe mental retardation, although may have average intellectual ability.

c. Etiology:
Most frequent cause of the accumulation of cerebrospinal fluid is a blocking of the circulation of the fluid which may be due to tumors, meningeal inflammations, other types of infections, or various types of injuries.

d. Incidence:
One percent of institutionalized individuals.

Seventy-five to ninety-four percent of all instances of mental retardation are of unknown etiology. Many cases of retarded mental development are clearly related to cultural and economic deprivation. Authorities today view the problem of etiology as one of interacting factors; the interaction of genetic factors with prenatal or postnatal environmental factors.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MENTAL RETARDATION VOCABULARY LIST

Cretinism	A condition which may result in mental retardation caused by insufficient secretion of the thyroid glands and characterized by small stature; short thick legs; disproportionately large head; short broad hands; dry coarse skin; large protruding tongue; short thick neck.
Developmental period:	That period of time from birth until approximately eighteen years.
Hydrocephaly:	A conditon often resulting in retardation caused by an accumulation of cerebrospinal fluid due to a blocking of the circulation of the fluid because of tumors, meningeal inflammations, other types of infections or various types of injuries. This condition is characterized by an unusually large head; in severe cases the bodies of such children are very slight and their necks cannot support the excessive weight of their heads.
Intelligence quotient:	A convenient way of representing the relationship between a child's mental and chronological ages. It is calculated by dividing the mental age by the chronological age and multiplying the obtained quotient by 100 (to remove the decimal figures).
Microcophaly:	A condition usually resulting in severe retardation caused by a recessive gene (primary form) or prenatal abnormalities such as excessive radiation, inadequate oxygen supply, and infections in the mother (secondary form). This condition is characterized by inadequate growth of the brain; a disproportionately small head of conical shape, with a receding forehead and flattened back part.
Mongolism: (Down's Syndrome)	A condition usually resulting in mental retardation caused by chromosomal abnormalities. This condition is characterized by almond-shaped slanting eyes, deep transverse fissure in the tongue, an absence of definite patterns in the lines of the palm of the hand; close-set, deep eyes which are often crossed; flattening of the bridge of the nose; a flaccidity of the muscles, thick stubby hands, very small fingers; short stature; subnormal weight; and lax bone joints.
Perseveration:	The tendency to continue an activity once it has been started and to be unable to modify or stop the activity even though it is acknowledged to have become inappropriate.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MENTAL RETARDATION FACT SHEET

Definition:

Mental retardation is characterized by significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. (American Association on Mental Deficiency).

Diagnostic Classification:

Mild Mental Retardation	I.Q.	52-67
Moderate Mental Retardation	I.Q.	36-51
Severe Mental Retardation	I.Q.	20-35
Profound Mental Retardation	I.Q.	Under 20

Education:

Mildly retarded:	Simplified school curriculum; adequate though modest social adjustment can be expected.
Moderately retarded:	Special academic and vocational training and guidance.
Severly retarded:	Institutional or some type of custodial care.

Diagnosis:

Criterion used:

(1) Intelligence quotient
(2) Developmental history
(3) Present functioning (academic and vocational achievement, motor skills, and social and emotional maturity)

Incidence:

3% of the general population (1970)

Etiology:

75-94% of the cases are of unknown etiology. Authorities today view the problem of etiology as one of interacting factors; the interaction of genetic factors with prenatal or postnatal environmental factors.

Characteristics:

Most retarded children have many of the following:

1. Delayed achievement of developmental skills such as sitting, walking, feeding, talking, and dressing.
2. Problems in gross motor and fine motor coordination.
3. Language disabilities and speech impairments.
4. Poor performance on verbal and nonverbal tests of intelligence.
5. Difficulty in concept formation - can deal with concrete material but have difficulty working with abstractions.
6. Short attention span.
7. Poor short-term memory skills.
8. Perseveration.
9. Trouble generalizing.
10. Social immaturity.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MENTAL RETARDATION REFERENCE SHEET

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
MENTAL RETARDATION HANDOUT

DEVELOPMENT CHARACTERISTICS OF MENTALLY RETARDED PERSONS

Degrees of Mental Retardation	Pre-School Age 0-5 Maturation and Development	School Age 6-20 Training & Education	Adult 21 & Over, Social & Vocational Adequacy
MILD (I.Q. 52-67 M.M.I. EDUCABLE)	Can develop social & communication skills; minimal retardation in sensorimotor areas; often not distinguished from normal until later age.	Can learn academic skills up to approx. 6th grade level by late teens. Can be guided toward social conformity. "Educable"	Can usually achieve social & vocational skills adequate to minimum self-support but may need guidance & assistance when under unusual social or economic stress.
MODERATE (I.Q. 36-51 S.M.I. TRAINABLE)	Can talk or learn to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision.	Can profit from training in social and occupational skills; unlikely to progress beyond second grade level in academic subjects; may learn to travel alone in familiar places.	May achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.
SEVERE (I.Q. 20-35)	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training.	May contribute partially to self-maintenance under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.
PROFOUND (I.Q. UNDER 20)	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Some motor development present; may respond to minimal or limited training in self-help.	Some motor & speech development; may achieve very limited self-care; needs nursing care.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
LEARNING DISABILITY OUTLINE

I. Historical Overview

   A. Relatively brief history
   B. Kirk suggested the term learning disabilities in 1963.

II. Definition

III. Specific Disabilities

   A. Behavior
   B. Learning Processes
   C. Academic
   D. Motor

IV. Diagnosis

V. Learning Approaches

VI. Incidence and Cause

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session #3

Script: Learning Disabilities

by
Karen Harper
Primary Curriculum Advisor

The field of learning disabilites has a relatively brief history. In the United States, the acceptance of learning disabilities as a comprehensive field of study begun in 1947 with the publishing of the book *Psychopathology and Education of the Brain-Injured Child* by Alfred A. Strauss and Laura Lehtinen. This book created a new category of exceptional children. Previously these children had been labeled emotionally disturbed, mentally retarded, lazy, stupid, careless, etc. To establish this category, Strauss perceived common behavioral and learning patterns in certain children and hypothesized that these behavior and learning patterns were manifestations of brain injury. Later educators and psychologists found the label brain-injured difficult to use and suggested other terms, such as, perceptually handicapped, minimal brain dysfunction, minimal neurological impairment, etc. Authorities felt that a term should be chosen which would describe the child's behavioral symptoms and thus the label learning disabilities gained wide-spread acceptance after being used by Kirk in the early 60's.

The term learning disabilties focuses attention on the child's problem rather than on the cause of the problem.

In 1969, Congress used the term learning disabilities when passing federal legislation to provide special programs for these types of children. (Overhead #1). The definition adopted by Congress as part of the "Children with Specific Learning Disabilities Act of 1969" is:

"Children wth specific learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which may have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbance, or to environmental deprivation". This definition is one of exclusion.

Children whose problems stem from sensory handicaps such as blindness or deafness, mental retardation, emotional disturbances, or cultural deprivation are not considered to be learning disabled. Thus before the classification of learning disabled can be applied, these other causal factors must be ruled out. This definition also infers a severe discrepancy between how a given child is expected to perform and how that child's is actually performing.

Children who are classified as learning disabled show a wide range of behaviors. Deficits in learning may occur in one or more of several areas. The most noticable area is that of behavior. The learning disabled child may be observed to have some of the following behavior patterns:

Hyperactivity - (Overhead #2) the child is excessively restless and often times is described as being constantly in motion.

Distractability - the child is easily distracted by visual and/or auditory stimuli.

Inattentiveness - it is difficult for the child to adequately focus on a task.

Impulsiveness - (Overhead #3) - children act without considering the consequences of their actions.

Perseveration - the child excessively repeats the same thought, word or action.

Low frustration tolerance - the child is easily frustrated.

Learning disabled individuals may exhibit deficits in one or more areas involving learning processes.

1. Percepton (overhead #4) - This is the means used to recognize and comprehend sensory stimulation. Thus this is how someone recognizes a chair when they see it whether it is upside down, on its side or standing right side up, or distinguish the sound of the telephone from the doorbell. The child who has a perceptual deficit may have difficulty learning to distinguish between a "b" and "d" (visual perception) or between the "o" and "u" sounds (auditory perception).

2. Memory (Overhead #5) - This is the ability to store information that has been sensed, perceived, and learned. It is also the ability to retrieve that information from storage when needed. A child with a memory deficit may have problems learning the alphabet, multiplication tables, etc.

3. Language (Overhead #6) - This is a communication system. It has two components: (a) receptive language which is the process of understanding verbal symbols. The child who has a receptive language deficit may have difficulty understanding sentences and thus if asked, "What did you do last night?" may reply "It's cold outside today". (b) Expressive language is the process of producing spoken language. Children with deficits in this area may be unable to remember specific words and may call their hamster a puppy.

4. Conceptualization is the ability to use abstractions, categorize, and think creatively and critically. This is the highest skill and may be adversely affected by a deficit in the lower levels (motor development, perception memory and language) as these other levels provide the base for the development of conceptual skills. Children with deficits in this area may be unable to perform such tasks as drawing inferences or reaching conclusions after reading articles.

The academic progress of a learning disabled child may show an uneven rate of growth (Overhead #7). The child may be functioning at grade level in math and two years below grade level in reading and spelling or above grade level in reading and significantly below in math. Reading is the most prevalent academic problem.

Many children who have difficulty learning also have difficulty with motor performance (Overhead #8). This may be manifest in dfficulty writing, skipping, balancing, playing baseball or any activity requiring motor skills.

When determining whether a particular child may be classified learning disabled, six factors should be considered.

1. The level of intellectual functioning should be determined. Students whose difficulties in school are due solely to a low level of intellectual functioning are not considered learning disabled. Intellectual ability should be determined by use of standard intelligence test (WISC, Binet, etc.). Care should be taken that the score achieved is indeed a true reflection of the child's ability and is not depressed by intervening factors.

2. It should be determined if there are vision, hearing, or other health problems which would interfere with the learning process or have interfered with the child's past development.

3. It should be determined if there are environmental, cultural, or economic disadvantages. Learning disabled students are not those students whose problems are due primarily to:

    a. Inadequate intellectual stimulation or experiences in early years.

    b. Poor or inappropriate instruction in school.

    c. Insufficient instruction as a result of frequent moves.

    d. Cultural, economic, or language differences.

4. It should be determined if there are social/emotional problems. Learning disabled students are not those students whose problems are due primarily to:

    a. Poor self-concept

    b. Negative attitude

   c. Low motivation

   d. Problems with peers or adults

   e. Family disruptions or problems. This does not mean that learning disabled students do not have emotional problems as they can develop social/emotional problems which will interfere with their adjustment and learning.

5. Analyze the children's academic achievement to determine if there is a discrepancy between their potential and actual achievement.

6. How the child learns should be analyzed. Factors to be considered are:

   a. Is the child's problem one of receiving information, expressing information, or processing and associating information?

   b. What are their strengths and weaknesses in learning visually, auditorily, and in intersensory tasks?

   c. What behavior characteristics do they display?

   d. How do they attack a learning problem?

In the 50's and 60's remediation was based on a process approach which emphasized remediation of perceptual-motor and processing problems. The rationale was that academic achievement would improve once and processing skills were learned. Research shows little evidence, however, that motor and perceptual motor programs result in significant academic gains and thus a prescriptive teaching approach has now evolved. This uses a problem-solving approach focusing on the actual skills that a child does or does not possess. It involves setting specific objectives for the child, planning and implementing a teaching strategy and finally evaluating the child's progress. Most learning disabled children are serviced through a resource program.

It is estimated that two to seven per cent of the population exhibits specific learning disabilities. Many professionals believe that "true learning diisabilities" are the result of a neurological disorder. This neurological dysfunctioning can be caused by:

1. Biochemical irregularities

2. Subtle prenatal brain damage

3. Circulatory, toxic or metabolic functioning difficulties as a result of disease during prenatal development.

4. Illness or injuries sustained during development and maturation of the central nervous system.

Today many children are classified learning disabled even though they do not exhibit evidence of neurological dysfunction so this is a controversial area.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

LEARNING DISABILITIES VOCABULARY LIST

Clinical teaching:	An approach to teaching that attempts to tailor-make learning experiences for the unique needs of a particular child. Consideration is given to the child's individualistic ways of learning and processing information.
Conceptualization:	The ability to use abstractions, categorize, think creatively and critically.
Conceptual disorders:	A disturbance in the thinking process and in cognitive activities, or a disturbance in the ability to formulate concepts.
Expressive language skills:	Skills required to produce language for communication with other individuals. Speaking and writing are expressive language skills.
Hyperkinesis:	Constant and excessive movement and motor activity.
Hypokinesis:	The absence of a normal amount of bodily movement and motor activity. Extreme lack of movement and listlessness.
Impulsivity:	The bahavioral characteristic of acting upon impulse without consideration of the consequences of an action.
Interneurosensory learning:	Learning that results from the interrelated function of two or more modalities in combination.
Intraneuron-sensory learning:	Learning that takes place predominantly through one sense modality.
Memory:	The ability to store and retrieve upon demand previously experienced sensations and perceptions, even when the stimulus that originaly evoked them is no longer present. Also referred to as "imagery" and "recall".
Minimal brain dysfunction:	A mild or minimal neurological abnormality which causes learning difficulties in the child with near-average intelligence.
Modality:	The pathways though which an individual receives information and thereby learns. The "modality concept" postulates that some individuals learn better through one modality than through another. For example, a child may receive date better through the visual modality than through his auditory modality.

Perception:	The process of organizing or interpreting the raw data obtained through the senses.
Perceptually handicapped:	A term applied to the person who has difficulty in learning because of a disturbance in his perception of sensory stimuli.
Receptive language:	Language that is spoken or written by others and received by the individual. The receptive language skills are listening and reading.
Resource teacher:	A specialist who works with children with learning disabilities and acts as a consultant to other teachers, providing materials and methods to help children who are having difficulty within the regular classroom. The resource teacher may work from a centralized resource room within a school where appropriate materials are housed.

PROJECT: C.H.A.N.G.E.
TITLE V C ESEA
LEARNING DISABILITIES FACT SHEET

Definition:

Children with specific learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which may have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbance or to environmental deprivation. (Adopted by Congress as part of the "Children With Specific Learning Disabilities Act of 1969)

Specific Disabilities:

Deficits in learning may occur in one or more of these areas:

1. Behavior:
    a. Hyperactive
    b. Distractible
    c. Inattentive
    d. Impulsive
    e. Perseveration
    f. Withdrawn
    g. Rapid changes in mood or temperament
    h. Easily frustrated
2. Learning Processes:
    a. Perception
    b. Memory
    c. Language (receptive, expressive)
    d. Conceptualization
3. Academics
4. Motor

Diagnosis:

1. Determine that the learning problem is not the result of low intellectual ability; vision, hearing or health problems; environmental, cultural, or economic disadvantages; social or emotional problems.
2. A discrepancy exists between potential and actual achievement.
3. Deficit in one or more of the basic learning processes.

Incidence:

Two to seven per cent of the population.

2. A discrepancy exists between potential and actual achievement.
3. Deficit in one or more of the basic learning processes.

Incidence:

Two to seven per cent of the population.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
SPEECH IMPAIRMENTS OUTLINE

I. Defective speech:

   a. characteristics
   b. classifications

II. Normal Speech development

   a. Poole Index on Order of Development of Consonant Sounds.

Age	Sounds
3½	m-p-b-w-h
4½	d-m-g-k-n (ng) j-x-y-tn
5½	f
6½	v-th-sh-l-ch-zh
7½	s-r-th (f) wh-z

III. Articulation Disorders:

   a. Definition
   b. Types
   c. Causes

IV. Voice Disorders

   a. Definition
   b. Types of voice disorders

V. Stuttering

   a. Definition
   b. Types of stuttering
   c. Physical gestures
   d. Causes of stuttering
   e. Classifications of stuttering

VI. Communication and Language Problems

   a. Definition
   b. Other communication and language disorders

VII. Conclusion

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 4

Script: Speech Impairments

by
Mary S. Smith
Coordinator

Defective speech is generally regarded as the type of speech that is marked by one or more of the following characteristics. It is unintelligible or indistinct. It draws attention to itself because it is conspicuous in its difference from the usual. It lacks ease, clarity and fluency. It interferes with communication. It hinders normal social adjustment.

Speech impairments vary with the individual and may take one of several forms: articulation disorders, voice disorders, stuttering or communication and language disorders.

The normal speech development of sounds has been classified. One of the most common classification systems is the Poole Index of Chronological Development of Consonant Sounds. (Put on Overhead marked #1). At age of three and a half, the child should be able to produce the consonants "m", "p", "b", "w", and "h". At four and a half, production of "d", "w", "g", "k", "n(ng)", "j", "y", and "tn" should occur. At five and a half, the only new sound acquired is"f", At six and a half years, "v", "th", "sh", "l," "ch", and "zh" should develop. Completion of sound development should occur at seven and a half years of age with the development of "s", "r", "th(Θ)", "wh", and "z".

In order for a sound to be considered impaired, the child must be over the age of normal development. An example of this would be a five year old child that can't produce the "r" sound. This is not defective. Yet, if that same child cannot produce a "k" sound he is exhibiting impaired speech.

(Put on Overhead marked #2). Articulation disorders are the most prevalant problems in school age children. An articulation disorder is an impairment of a child's ability to produce speech sounds correctly. There are three types of articulation disorders. The first is omission. (Put on Overhead marked #3). An omission occurs when a sound is omitted in all or some words, phrases or sentences. An example of this is: "I'll eed the ish some ood."

(Put on Overhead marked #4). The second disorder is substitution. A substitution occurs when one sound is produced for another sound. An example of this is: "Look at the punny pat pog."

The third type of articulation disorder is distortion. (Put on Overhead marked #5). Distortion is the production of an approximated sound (a sound close to the desired sound). An example is: "See the nice fpish my fpather and I caught." All of these defects can occur in a child's speech and at different word locations (initial, medial and final).

The cause of articulation disorders is either organic or functional. An organically caused disorder results in the child's being physically unable to produce the sound. Organic causes are: cleft lip and palate, hearing loss, cerebral palsy and dental abnormalities.

A functional articulation disorder is when the child has the physical capability of correctly producing the sound but does not do so. The most common functional causes are poor speech models or poor speech production habits (improper tongue placement). Poor home motivation may also be an influencing factor.

Another category of speech impairments is voice disorders. (Put on Overhead marked #6). A voice disorder is any pitch, intensity or quality characteristic of the voice that is atypical for the speakers age or sex. It can be either organic or functional.

There are several types of voice disorders. (Put on Overhead marked #7). The first is respiration - problems arising from abnormal breathing during speech production. The second type is phonation problems which usually are the result of laryngeal (larynx) problems such as hoarseness, monotone, and pitch defects. Finally resonance problems are characterized by impaired sound quality due to problems in the oral or nasal cavity. Denasality (too little air expulsion) and nasalty (too much air expulsion) are an example.

In speech impairments one of the most easily observable disorders is stuttering. Stuttering is a communication disorder characterized by behavior which interfereswith forward moving speech and is considered abnormal by the listener. The area of stuttering also has a classification system. One form is a stoppage. A stoppage is the repetition of an initial position sound. An example being: "I can't t-t-t-t-talk now." Hesitations are the use of fillers in a sentence or a long inappropriate pause in speech production. An example of a filler is: "You u. u. u. want to uh uh go tb the uh uh show?" An example for a pause is: "You want (pause) to (pause) go to (pause) the (pause) show?"

Another problem which occurs is repetitions. (Put on Overhead marked #8, this is the last overhead). A repetition is the repeated production of the first syllable of a word. For example, "See the daw-daw-daw-dog."

A form of stuttering not sighted too frequently is a prolongation. A prolongation is the fixation on a sound or syllable for a long period of time. The physically inappropriate gestures which can hinder a stutterer in communicating are: tremors, eye movements, head jerks, quick breath rate, finger snapping, hair twirling and leg swinging.

At this time, the available research on stuttering indicates that in most cases, the cause is unknown. The most commonly suspected causes are:

1. coordination or timing
2. phonation problems
3. emotional problems

Stuttering or non-fluency has two general stages, primary and secondary. Primary stutterers are slow to increase in their problems. A secondary stutterer is aware of the problem and has related fears in a speaking situation.

In the last five years, language problems have become the focal point of communication disorders. A language problem is the inability to communicate due to:

1. inability to understand or use a wide vocabulary
2. improper grammatical structures
3. inability to respond appropriately to questions
    a. repeating a part or the complete question (after the speaker without apparent comprehension)
    b. no response to the question
    c. responding clearly with an answer not relative to the question.

Other speech impairments which are not commonly seen in the elementary schools are aphasia and laryngectomies. The word aphasia means without language. Therefore, aphasia is an impairment of the ability to use or understand oral language. In speech terms, this generally means an aphasic is a person who has had a "C.V.A." (cerebral vascular accident - stroke) and subsequently a lesion in the brain has caused interference in the language process either receptively or expressively.

The term laryngectomee applies to the person who had a laryngectomy (an operation by which parts of or the entire larynx is removed). The removal of the larynx is generally due to cancer.

Speech after surgery is different from normal production. The types of speech are usually esophageal (air expulsion) or an artificial larynx (a mechanical device).

Speech impairments can range from a mild articulation problem to an artificial system of speech or no communication system at all (aphasia - in its' severest form). Keep in mind that without a communication system, man is a prisoner within himself.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
SPEECH IMPAIRMENT VOCABULARY LIST

Speech Impairments:

Omission -	An omission occurs when a sound is omitted in all or some words, phrases or sentences. An example is: "I'll eed the ish some ood."
Substitution -	A substitution occurs when one sound is produced for another sound. An example of this is: "Look at the punny pat pog."
Distortion -	A distortion is the production of an approximated sound (a sound close to the desired sound). An example is: "See the nice fpish my fpather and I caught."
Voice Disorder -	Is any pitch, intensity or quality characteristic of the voice that is atypical for the speakers age or sex.
Aphasia -	Without language.
Stuttering -	Non-fluent speech.
Laryngectomy -	A person who has had an operation by which parts of, or, the entire larynx is removed.

B

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

SPEECH IMPAIRMENTS FACT SHEET

1. Characteristics of defective speech are:

    a. unintelligible or indistinct
    b. draws attention to itself
    c. lacks ease, clarity and fluency
    d. interferes with communication
    e. hinders normal social adjustment.

2. Speech impairments vary with the individual and may take any of these forms:

    a. articulation disorders
    b. voice disorders
    c. stuttering
    d. communication and language disorders.

3. The three types of articulation disorders are: omissions, substitutions and distortions. Articulation problems are most commonly found in children.

4. Organic disorders which can cause articulation defects are:

    a. cerebral palsy
    b. cleft lip and palate
    c. hearing loss
    d. dental abnormalities

5. Functional disorders are caused by poor speech models or poor speech production habits.

6. Stuttering is still being researched and the cause is unknown. It is a communication disorder characterized by interference with forward-moving speech and is considered abnormal by the listener.

7. Aphasia means without language. The side of the body weakened or paralyzed by the stroke is the one opposite to the side of the brain affected. Ex., a lesion occuring on left side of the brain would cause paralysis on the right side of the stroke victim.

8. Cerebral palsied children represent all levels of intelligence and can range from normal to defective.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

SPEECH IMPAIRMENTS REFERENCE SHEET

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
DEAFNESS OUTLINE

I. Classifications of Hearing Loss

- A. Types of Deafness
- B. Types of Hearing Loss

II. Causal Factors

- A. Endogenous Factors
- B. Adventitious Factors
- C. Congenital Factors

III. Statistical Factors

- A. Prevalance Estimate
- B. Disability Populace

IV. Developmental Factors

- A. Early Identification
- B. Perceptions
- C. Obstacles

V. Hearing Measurement

- A. Audiometrics
- B. Degrees of Hearing Impairments

VI. Academic Learning

- A. Intelligence
- B. School Setting
- C. Problems

VII. History of Sign Language and Fingerspelling

- A. Sign
- B. Fingerspelling

VIII. Communication Methods

- A. Total Communication
- B. Manipulative Methods
- C. Speech Reading

IX. Conclusion

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 4

Script: Deafness

by
Mary S. Smith
Coordinator

Loss of hearing is a common problem affecting fourteen-and-a-half million Americans. We live in a noisy world where the environmental sound level is high. Not all of the sounds we hear are important, but language, danger sounds and music are important components of our world. The deaf individual must live in silence. Their hearing loss dramatically affects their learning and life since it hinders communication.

There are several classifications of hearing loss. The term "deaf" refers to those in whom the sense of hearing is non-functional for the ordinary purposes of life. Deafness is considered to be the most dehabilitating handicap since it hinders the establishment of speech and natural language. In the deaf, the ability to speak and understand language is not always present.

The term "congenitally deaf" refers to those who were born deaf. Those born with normal hearing but in whom the sense of hearing becomes non-functional are referred to as the "adventitiously deaf", The last classification is "hard-of-hearing" which refers to those in whom the sense of hearing, although defective, is functional with or without a hearing aid.

(Put overhead #1 of ear on.) There are two types of hearing loss. The conductive loss which affects the middle ear and the sensorineural which affects the inner ear. (Point to the middle ear and the inner ear on the diagram while naming their illustrated components.)

We will now cover the causal factors. The endogenous causal factors for a hearing impairment are genetics, heredity and congenital. The genetic factors which can cause deafness are generally RH blood type, German Measles (Rubella) and on occasion premature birth.

The adventitious causal factors can be: complications of childhood diseases, spinal meningitis, encephalitis, drugs or accidents which damage the nervous system or other avenues of hearing. Congenital deafness (born deaf) is usually considered a more severe handicap since the child was always deaf and there was never an opportunity to acquire language.

According to the official prevalence estimate of the United States Office of Education, less than one per cent of school age children are hearing-handicapped. Therefore, there are more adventitiously deaf (those born with normal hearing but in whom the sense becomes non-functional) than those born with a hearing disability.

Early identification is a primary factor in language development. It is of extreme importance to identify the child who is deaf at an early age. The infant who is deaf and is not identified gains nothing in the area of natural language.

Infants acquire knowledge through their perceptions. Sensory perceptions play a major role in early concept formation. A deaf infant will see the parent's mouths move but will not associate this movement with sound. The deaf infant will cry when hungry just as a hearing infant but he will not realize that the noise made (voice) is a summons to the parent.

The three biggest obstacles for the deaf are normalcy, education and communication. The questions which arise regarding normalcy are: Will the child ever be normal and hear? In the educational setting the problem area is in the presentation of material. A visual approach is needed. Not all of the material presented in a curriculum is available in a visual approach. An example of this is trying to teach a child the sound which is associated with a specific letter.

The third and largest obstacle is communication. Not all deaf people are capable of producing oral language. Because of this, an alternative method of communicating such as sign language is used by the deaf. The problem here, of course, is that not everyone knows sign language and communication is limited to the specific individuals who are capable of understanding the message.

These obstacles of normalcy, education and communication are of great concern to the parents. The majority of deaf children are born to hearing parents who must adjust the families interpersonal communication system to include the deaf child.

Hearing Measurement is a term associated with the instrument and testing procedures which assess the individual's level of hearing. Several terms which are important in the measurement of hearing will now be covered. An audiogram is a chart plotting the hearing threshold of an individual. (Put overhead #2 of audiogram on). The audiometer is the instrument which measures the decibel level. (Point to the db column on the audiogram). The decibel level or db refers to the loudness or softness of a sound. The term Hertz of Hz refers to the highness or lowness of the sound (pitch).

A screening test checks the level of hearing at 25 db at 250, 500, 1000, 4000 and 6,000 Hertz. If an individual fails to pass the screening a pure tone threshold is given. On the threshold, the same Hertz (frequency) are tested but are checked to determine the child's exact level of hearing.

The audiologist is the trained specialist. An audiologist must have a degree. Their training program concentrates on the use of appliances and instruments designed for testing and amplification of hearing loss. They must be aware of all the causes and types of hearing loss, as they prescribe the specific type of hearing aid (if any) to be used by the client.

In the public school system and clinics, the nurse does the hearing screening test and pure tone thresholds (audiogram-standard test) when necessary. The nurse must possess a certificate from the State to perform these tests. Requirements are a minimum number of courses in audiology and a training practition. Refresher courses are mandated every several years. The nurse makes appropriate medical referrals and recommendations to the family and classroom teacher based on the child's level of hearing.

Degrees of hearing impairment are classified as mild, marked or severe. These degrees are used to assist in determining educational placement. The deaf child or severly hearing impaired child has a problem on these and other types of tests due to difficulties in communication and lack of language experiences.

The highest determiner of intelligence on most standardized tests is the verbal performance score. A non-verbal person cannot be expected to achieve on a test designed to measure the ability level of a verbal person. Therefore; most intelligence tests are biased against the deaf individual. With deaf children, there is another complication in testing. They do not always understand that a test is being timed and that they are to try and finish the test in a required time.

Most testing in the educational system is done by a trained and certified school psychologist. The psychologist will probably not be fluent in sign language or fingerspelling so the directions given preceding the test will not be understood by the deaf child.

The primary areas which are measured on an intelligence test are language and mathematics. When a deaf child is tested, there is usually a large discrepancy between the score with the mathematics area being the higher score. Deaf children can usually achieve when dealing in the concrete areas such as mathematics. Language scores must be expected to be lower as the experiences of a child deaf from birth will be severely limited in the highly abstract and symbolistic realm of language.

The biggest danger that occurs in a testing situation is that a low intelligence quotient can be wrong. The deaf child can be misplaced in an academic setting. It is harder to achieve a high intelligence quotient score and have it be inaccurate due to the evaluation design of the assessment instruments.

There are two major types of school settings available to the deaf child. The first is the state or private residential schools for the deaf. The second type is the local day classes for deaf children which are conducted by specially trained deaf education teachers within the public or private sector.

Most hard-of-hearing children are in the public school setting. These children are in regular classes receiving supportive service provided by a speech pathologist or a teacher of the deaf. Most children who are deaf or hard-of-hearing are guaranteed to be in the lower reading groups if not even several grades behind due to their severe communication problems.

We will now cover the history of sign language and fingerspelling. The Abbe de L'Eppe is said to be the inventor of sign language. Sign language originated in Paris, France. Fingerspelling is much older than the language of signs. It is the use of hand positions to represent the letters of the alphabet. The manual alphabet was illustrated in the Christian era. The Latin Bibles of the tenth century also used this alphabet. It is believed the monks helped lengthen the manual alphabet as they lived in enforced silence and this was an alternative method of communication.

There are many ways of communicating. "Total communication" is a theory which stresses the right of the teacher and the deaf child to use all available forms of communication to develop a frame of reference for language and fundamental concepts. These forms may include: child devised gestures, amplification, speech, lipreading (speech reading fingerspelling (the one-hand manual alphabet), sign language, a language board, and writing.

Sign language is ungrammatical in terms of the English language. American Sign Language (A.S.L.) is the typical language deaf people use when conversing among themselves. A.S.L. has a grammatical structure like the Chinese language. Each sign represents an entire concept not just a word. Amselan is an aeronym for A.S.L. The word Amselan was coined to lend more dignity to the language as initials do not provide an element of respect. All forms of sign language are symbolized (representing concepts) and do not conform to the strict structure of English grammar.

Fingerspelling (the one-hand manual alphabet) is the use of the manual alphabet to spell words. A knowledge of spelling and grammatical rules is necessary to use this form of communication. The manual alphabet consists of a single hand configuration for each letter of the English alphabet. A benefit of fingerspelling is that any word may be spelled. When dealing with abstract ideas or technical names, this is of great benefit to a deaf person. Another name for fingerspelling is the Rochester Method.

When fingerspelling, always spell with the palm of your hand toward the deaf person. Learn to form the letter with the fingers only. Do not bend the wrist. No pause or stop is made between letters or words. With practice, you learn to distinguish between the ending of one word and the beginning of another. Fingerspelling is a slow method of communication.

Another communication method is Manual English. Manual English is a combination of signs and fingerspelling which adheres closely to the grammatical structure of the English language. Manual English differs from Ameslan in that Ameslan has its own structure as a language. Thus, Manual English is a manual-visual representation of the English Language.

Manual English is becoming a very popular form of communication. It is a fast and easy way for the deaf to communicate. Fingerspelling an entire conversation out is a long and monotonous process. By mixing sign language (a faster form of communicating) with fingerspelling, deaf individuals can convey their message quickly and fingerspell an abstract word or idea which may not be able to be conveyed in sign.

The term speech reading is used interchangeably with lipreading. Speechreading is the more appropriate term. This process involves visual focus not only on the lips of the individual who is speaking but includes an assessment of all the facial and body expressions involved while the speaker is communicating. Speech reading is not a natural ability. It is a learned process that has been erroneously credited as a natural ability of the deaf. Some hearing people are better speech readers than the deaf. The more observant the person the better chance they have of becoming a good speech reader.

The ability of speech reading is a desirable asset for the deaf person to acquire. Speech reading requires a lot of practice. Not all of the sounds we make are visually distinguishable. An example of this are the words, Italian and Indian. If these two words are said without the use of voice, it is hard to distinguish which word has been produced. A good speech reader catches the general idea of the conversation but really can identify about only every third word which has been spoken. Speech reading is a desirable skill to possess but cannot be relied upon as the sole method of receiving information.

Deafness is the most disabling of all handicaps. It locks the mind into the body and takes away communication, the path where minds are enabled to meet. The only sound to be heard is silence.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

DEAFNESS VOCABULARY LIST

Congenitally deaf: those who were born deaf.

Adventitously deaf: those born with normal hearing but in whom the sense of hearing became non-functional.

Hard of Hearing: those in whom the sense of hearing, although defective is functional with or without a hearing aid.

Types of hearing loss: conductive: affects the middle ear
sensorineural: affects the inner ear

Sign language (ungrammatical) Types:

A.S.L. - American Sign Language: this type of sign has a concept structure.

Amesian - This type of sign is a combination of fingerspelling and sign.

Fingerspelling: The one hand manual alphabet has a grammatical basis.

Manual English: A combination of sign and fingerspelling with it's own Language structure. It is grammatical.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

DEAFNESS FACT SHEET

1. Causal Factors - The endogenous causal factors for a hearing impairment are genetics, heredity and congenital.

2. Statistical Factors - According to the official prevalence estimate of the United States Office of Education, less than one percent of school age children are hearing handicapped. There are more adventitiously deaf than those born with a hearing disability.

3. The three biggest obstacles for the deaf individual are:

   a. Normalcy - Will he ever be normal or hear?
   b. Education - A visual approach is needed.
   c. Communication - Oral or sign?

4. The greatest majority of deaf children are born to hearing parents.

5. Lip reading has more recently been named speech reading. Speech reading is not a natural ability. It must be learned.

6. An audiogram is a chart plotting hearing threshold. An audiometer is the instrument used to test a client's hearing. The audiologist is the trained and certified technician.

7. The degrees of hearing impairment are mild, marked and severe.

8. Sign language is a symbolized language which does not conform to the structure of English.

9. Intelligence tests are language and mathematics based. A discrepancy usually exists in a deaf child's performance as language is the area of the handicap.

10. Deafness is the most disabling of all handicaps.

11. There are fourteen and one-half million deaf in the United States.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
DEAFNESS REFERENCE SHEET

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YOU HAVE TO BE DEAF TO UNDERSTAND

by Willard J. Madsen

What is it like to "hear" a hand?
You have to be deaf to understand!

What is it like to be a small child,
In a school, in a room void of sound–
With a teacher who talks and talks and talks;
And then when she does come around to you,
She expects you to know what she's said?
You have to be deaf to understand.

Or the teacher who thinks that to make you smart,
You must first learn how to talk with your voice;
So mumbo-jumbo with hands on your face
For hours and hours without patience or end,
Until out comes a faint resembling sound?
You have to be deaf to understand.

What is it like to be curious,
To thirst for knowledge you can call your own,
With an inner desire that's set on fire––
And you ask a brother, sister, or friend
Who looks in answer and says, "Never mind!"?
You have to be deaf to understand.

What is it like in a corner to stand,
Though there's nothing you've done really wrong,
Other than try to make use of your hands
To a silent peer to communicate
A thought that comes to your mind all at once?
You have to be deaf to understand.

What is it like to be shouted at
When one thinks that will help you to hear;
Or misunderstand the words of a friend
Who is trying to make a joke clear,
And you don't get the point because he's failed?
You have to be deaf to understand.

What is it like to be laughed in the face
When you try to repeat what is said;
Just to make sure that you've understood,
And you find that the words were misread––
And you want to cry out, "Please help me, friend!"?
You have to be deaf to understand.

What is it like to have to depend
Upon one who can hear to phone a friend;
Or place a call to a business firm
And be forced to share what's personal, and,
Then find that your message wasn't made clear?
You have to be deaf to understand.

What is it like to be deaf and alone
In the company of those who can hear–
And you only guess as you go along,
For no one's there with a helping hand,
As you try to keep up with words and song?
You have to be deaf to understand.

What is it like on the road of life
To meet with a stranger who opens his mouth––
And speaks out a line at a rapid pace;
And you can't understand the look in his face
Because it is new and you're lost in the race?
You have to be deaf to understand.

What is it like to comprehend
Some nimble fingers that paint the scene,
And make you smile and feel serene
With the "spoken word" of the moving hand
That makes you part of the world at large?
You have to be deaf to understand.

What is it like to "hear" a hand?
Yes, you have to be deaf to understand!

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
DEAFNESS

INDEX OF NORMAL INFANT AUDITORY BEHAVIOR

Age	Expected Response
0-6 weeks	Eye widening. Stirring or arousal from sleep. Startle or eye blink.
6 weeks to 4 months	Eye widening, eye shift, quieting, beginning of rudimentary head turn. Eye blink, quieting, beginning of head turn.
4-7 months	Head turn on lateral plane toward sound. "Listening" attitude.
7-9 months	Direct localization of sounds to side or below ear level.
9-13 months	Direct localization of sounds to side or below ear level indicated above.
13-16 months	Direct localization of sounds on side, above and below.
16-21 months	Same
21-24 months	Same

Child responds to the following sounds: Noisemakers (bells, squeeze toys, rattles) warbled pure tones, hearing test - speech.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

EPILEPSY OUTLINE

I. History of Epilepsy

   A. Ancient views
   B. Historical treatments

II. Cerebellum Functions

   A. Electrochemical body system
   B. EEG patterns

III. Types and Descriptions of Seizures

   A. Grand Mal
   B. Petit Mal
   C. Psychomotor Attack

IV. Causes of Epilepsy

   A. Symptomatic
   B. Idiopathic

V. Seizure Control

   A. Medication
   B. First aid for epileptics

VI. Statistical Occurences

   A. Current trends
   B. Progress through knowledge.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 5

Script: Epilepsy

by:
LaVerne Galzin, R.N.
Medical Consultant

Epilepsy is probably the oldest known disorder of the brain. It was mentioned in the laws of Hammurabi, the King of Babylonia, more than two thousand years before Christ. The disease was known to the ancient Egyptians and to the ancient Hebrews.

Even in the early days, there was a battle between the superstitions of the general public and the more scientific ideas of doctors, who observed epilepsy more carefully. The great Greek physician, Hippocrates, wrote a book "On the Sacred Disease" in 400 B.C. In it he said, "The sacred disease appears to me no more divine, nor more sacred than other diseases... men regard its nature and causes as divine from ignorance. It was a popular thought that epileptics were considered holy and that the confused mutterings they might utter just before an attack were treasured as inspired prophecy. The ancients believed that an epileptic was seized by a god or demon who took possession of his mind and body and caused him to fall down writhing. In fact the modern term "epilepsy" comes from a Greek word meaning "seizure".

The views of ancient physicians are quite similar to what is now known about the disease. They believed it was a disease which begins in the brain. Galen, a Greek physician who lived about 500 years after Hippocrates, described the warning signs that often come just before an epileptic seizure and introduced the word "aura", a term which is still used today. (One of Galen's patients described his warning signs as "Like a cold breeze' and the word aura originally meant "breeze".) Although these views were known, it took a long time before they were accepted. During the Middle Ages, there was a widespread belief that epileptic seizures were due to possession by demons. In the sixteenth and seventeenth centuries, most people believed firmly in Satan and his devils. Sometimes, a distinction was made between the natural disease, epilepsy and demonic possession.

Physicians were called in to test the suspected patient. Sometimes epilepsy itself, was thought to be caused by withcraft. During this time, many superstitions about epilepsy grew. It was thought the disease was contagious, and that anyone exposed to the breath of a person having a seizure could catch the disease. So epileptics were often treated like lepers and special isolation hospitals were built for them.

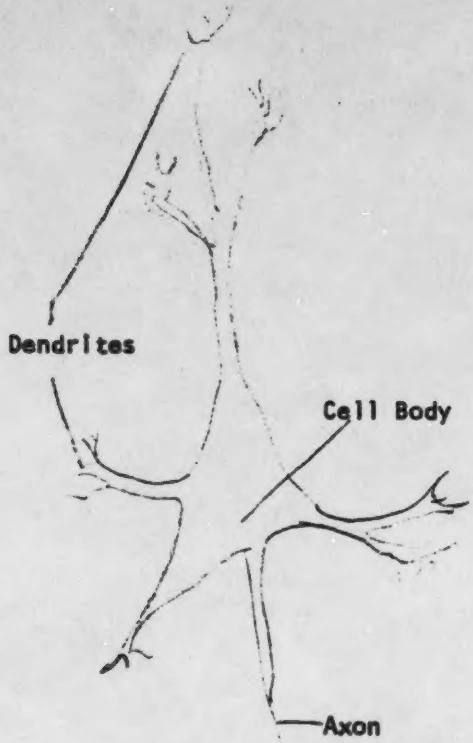
Another theory held that epilepsy was controlled by the moon. Treatments for epilepsy ranged from strange concoctions such as frog's liver, dog's blood, human urine, or peony juice, to applying hot irons to the head and even cutting a small hole in the skull to allow mischievious matter to escape.

Doctors today are inclined to think of epilepsy not as a single disease, but rather as a group of effects resulting from a disturbance in the brain's electrical activity. For some types of epilepsy, the causes are known; for others, the causes remain a mystery.

It may seem strange to think of electricity in the brain. Actually electricity is a normal part of the brain's activity. The human brain is made up of about 30 billion neurons or nerve cells.

A neuron has branches on each end. These branches link the neuron of the brain together into complex, three-dimensional networks. Each neuron acts like a tiny storage battery. It builds up an electrical charge through reactions of the chemicals it contains. It can then discharge and pass the electrical impulse on to the next neurons in the chain.

Brain cells do not multiply like other cells in the body. An individual is born with all the brain cells he will ever have. With age, they may deteriorate and die, but because of sheer numbers, the effect is not usually noticeable until extreme old age, and sometimes not even then.



Neuron (nerve cell)

The human brain contains billions of these microscopic, threadlike, nerve cells. Dendrites conduct information to the cell body, and the axion conducts from the cell body to other nerve cells or muscles fibers.

(Put on Overhead #1). The invention of the electron microscope has enabled scientists to "see the different parts of a neuron. Basically, it is a single jelly-like cell, covered with thin membrane. At one end are the "Dendrites," tiny, furry, looking branches that pick up electrical impulses. At the other end is the "Axon", a thin bundle of fibers that transmit the impulse to the dendrites of the next cell.

How the electrical impulses move from one cell to the next. The impulse is picked up by the dendrite, moves along the polarized surface of the membrane and on to the axon. Between cells there is a tiny gap, called the synapse, or synapter cleft. This has been described as the decision-making center for the cell. Here the impulse is either passed on, probably by the minute quantities of chemicals which flow across the synapse - or it is stopped. Although some cells have their own "feedback" system that inhibits the passage of impulses, in most, the current moves in only one direction. It is believed that some cells always pass on the impulse, and others always inhibit it.

The electrical energy in a nerve cell comes from the metabolism of the cell, where enzymes break down glucose molecules, releasing the energy that bound them together. Excess energy is stored in phosphates also present in the cell...... a kind of living battery with power to spare for sudden emergencies when the body needs more than usual.

The constant electrical activity can even be detected at the outside of the head. If electrodes (metal wires or disc) are pasted to the scalp, a current flows through them. This current is very tiny - so tiny that it must be amplified many times before it can be recorded and measured. Neurons in the brain discharge electrical energy in regular bursts, like waves. The machine that is used to pick up and record this electricity is called an electroencephalograph (EEG). The readings vary characteristically depending on whether the person is alert, relaxed, drowsy or asleep.

For a normal adult, the EEG shows a pattern or waves, about 10 a second. But during an epileptic seizure, the EEG shows great bursts of energy, which comes either much more or less frequently than usual. A person who suffers from epilepsy usually shows an irregular EEG Pattern even when he is not actually having a seizure.

During an epileptic seizure, there is a sort of electrical storm in the brain, neurons become overactive and fire off irregularly. The disturbance may spread to nearby neurons, jump to more distant ones or race like wildfire through the whole brain. When this happens, all the brain activities temporarily come to a halt. The person having a seizure may lose consciousness. His muscles may first go rigid and then begin contracting convulsively. He may even stop breathing. But soon the electrical storm in the brain quiets down. Most of the neurons begin working in harmony again and the seizure is over.

Kinds of Seizures. (Only three types will be discussed). Epilepsy may show itself in a number of different ways. The kinds of seizures a person has is determined by where the electrical disturbances in the brain begin, where it spreads and how fast it spreads. Generally, each epileptic tends to have only one kind of seizure, but occasionally they can have more than one type.

The commonest kind of epileptic seizure is called "grand mal", which literally means a "great illness". The person loses consciousness; the body stiffens, the tonic rigidity soon passes and is replaced by rapid jerking of limbs and/or trunk, neck, eyes and/or face. His breathing is shallow or may seem to stop entirely. This usually lasts from 2 to 5 minutes, but can last from less than a minute up to 1/2 hour or more. If it is very brief, the person may be able to go back to his normal activities within a few minutes. But after a long seizure, the person usually slips directly into a deep sleep. When he awakens, he may be weak and confused, restless and irritable. Nausea, vomiting, headaches, muscle soreness and abnormal behavior may also follow such a seizure. This may last for only a moment or two or may persist for a longer period of time.

Another type of seizure is so mild that family, friends, teachers and even the person himself may not notice it. This is petit mal (little illness). The person having a seizure simply stops and stares into space for a moment. He may or may not blink his eyes rapidly or twitch his hands slightly - this may last for 5 to 25 seconds. During this time the individual is not aware of his surroundings. He may have a behavior or learning problem as a result of this off-on contact with his environment. Petit mal seizures may occur up to 100 per day, usually in persons between 6 and 14 years of age, but they may also occur in adults. After a petit mal seizure, the individual's activity continues as if nothing has happened.

The third type of seizure we will discuss is "psychomotor attack." This form gets its name from the fact that the abnormal discharge acts on both the mental processes ("psycho") and the muscles ("motor"). The individual may stop what he is doing and begin some automatic, repetitive movement, such as stroking his hair, rubbing his leg or plucking at his clothes. He may make chewing movements with his mouth or repeat short senseless phrases over and over. These purposeless movements are called automatism. During the seizure, the person is not unconscious, but he is in a sort of dream state. Afterwards, he will remember little or nothing of what happened during the attack. Psychomotor epilepsy is often called temporal lobe epilepsy, because the focus is usually in one of the temporal lobes. This may last 2 to 5 minutes and occur one or more times weekly, monthly or annually.

Causes of Epilepsy:

Seizures are sometimes classified as symptomatic or idiopathic. In symptomatic epilepsy, attacks can be traced to a specific injury to the brain. Perhaps there was an injury during birth when the skull was still very soft (the affects of such an injury may show up in early childhood, or not until many years later). A skull fracture in which a bit of bone presses on the brain can also cause epileptic seizures. So can certain diseases, such as meningitis (an inflammation of the membranes that surround the brain) and encephalitis (an inflammation of the brain itself). Brain tumors can also produce seizures. But for many cases there are no apparent causes. (This does not necessarily mean that there is not a specific cause, just that it has not been discovered). Such cases are called idiopathic.

There is a great deal of disagreement about how important heredity is in regard to epilepsy. Probably it is not epilepsy itself that is inherited but a tendency to react to damage to the brain with seizures. Febrile (fever) convulsions sometimes occur in some children during an illenss; many times this is an indication of future problems. In the growing child and adolescent, there are many important changes in the body chemistry, particularly in the hormones produced by the glands. Then chemical changes can trigger epileptic seizures. For epilepsies that first appear in young adults, the leading causes are head injuries and tumors as well as the delayed effects of birth injuries.

From middle age onward, brain tumors and blood vessel diseases resulting in poor circulation in the brain become increasingly important causes of epileptic seizures. But only a small fraction -- perhaps 8% -- of all cases of epilepsy begin this late in life.

Controlling seizures. When the individual has been thoroughly examined to discover if there is a specific cause of the seizures, such as a brain tumor, etc., the doctor usually begins a program of treatment with medication. Doctors are not entirely sure how anticonvulsant drugs work, but it is believed that they work on the nerve cells around the abnormally discharging neurons to make them less excitable. The particular drugs to be used in each case and the doses that are most suitable for the individual have to be worked out very carefully. People differ in the way they absorb drugs into the blood stream, use them in the body and excrete them.

Once the proper combination of drugs is worked out, about 50% of epilepsy patients can be completely freed of seizures and for about 30 to 35% the number of seizures is greatly reduced. Usually the drugs are taken two or three times per day and the patient must be very careful never to skip a dose. If he does, a seizure may result.

Some epileptics must continue taking these medications for the rest of their life. It has been found that children often "outgrow" epilepsy. Their seizures become less frequent as they grow older and may disappear. After a few years of control of seizures through drugs, the doctor may - slowly and carefully - decrease the dosage. The patient may eventually be able to remain free of seizures without taking medications.

Occurrences. Alexander the Great, Napoleon Bonaparte, Julius Caesar, Lord Byron, Dante, St. Paul, Martin Luther, Vincent VanGogh, Charles Dickens, Socrates - these are just a few famous people of history who had epilepsy. There are approximately 4,000,000 persons in the United States believed to have epilepsy and 80% of the cases are usually seen in the first 19 years of life. It is believed the number is far greater but because of lack of knowledge of the general public and prejudice combined with fear, the exact number is not known.

Researchers, scientists and doctors are actively exploring this disease at the present time. Surgery, biofeedback studies and new chemicals are just a few of the future possibilities that are being explored.

We have discussed only the medical aspects of epilepsy to try to dispel some common misconceptions about the disease. The social and emotional aspects of this disease are as important as the medical aspects. It is totally impossible to cover every aspect of epilepsy in a short period of time. (Additional information may be obtained by referring to the book list on the last page.) What the epileptic needs most is understanding from the people around him. He needs to be treated as a person, not as an object of fear. Progress is being made in this area too - but change comes slowly. As more people learn the facts about epilepsy, epileptics have a better chance of being accepted and can live and grow to their full potential.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
EPILEPSY VOCABULARY LIST

Epilepsy - comes from a Greek word meaning 'seizure'.

Aura - is a term used to describe the warning sign or feeling prior to a seizure.

A neuron - is composed of a cell body, axons and dendrites. Neurons are microscopic threadlike nerve cells in the human brain. The brain contains billions of neurons.

Dendrites - are nerve endings that conduct information to the cell body.

Axons - are a thin bundle of fibers that transmit impulses to the dendrites of the next cell.

Electroencephalograph (EEG) - is the machine used to record the electrical (energy) discharge of the brain.

Grand Mal - means great illness.

Petit Mal - means little illness.

Psychomotor attack epilepsy - is often called temporal lobe epilepsy, because the focus is usually in one of the temporal lobes of the brain.

Symptomatic epilepsy attack - can be traced to a specific injury to the brain.

Idiopathic epilepsy - does not necessarily mean that there is not a specific cause - just that it has not been discovered.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
EPILEPSY FACT SHEET

1. Epilepsy is not thought of in terms of a single disorder, but rather as a group of effects resulting from a disturbance in the brain's electrical activity.

2. Epileptics generally show an irregular EEG pattern.

3. Grand Mal is the most common type of epileptic seizure. The person loses consciousness; the body stiffens; the tonic rigidity soon passes and is replaced by rapid jerking of limbs and/or trunk, neck, eyes and/or face. Breathing is shallow. This seizure usually lasts from 2 to 5 minutes, but can last from less than a minute up to half hour or more. If the seizure is brief, the person may be able to go back to normal activities within a few minutes. After a long seizure, the person usually slips directly into deep sleep. Symptoms of confusion, restlessness, nausea, vomiting and abnormal behavior may follow such a seizure.

4. Petit Mal seizures are the brief absences of consciousness which occur predominately in children. Petit Mal seizures may occur up to 100 times per day, usually in persons between six and fourteen years of age, but they may also occur in adults. The person having a seizure simply stops and stares into space for a moment. Slight eye blinking and hand twitching may or may not occur. If it does occur, it may last for 5 to 25 seconds. During the seizure, the individual is not aware of his surroundings. A behavior or learning problem may result of this off-on contact with the environment. After a petit mal seizure, the individual's activity continues as if nothing has happened.

5. "Psychomotor Attack" derives its name from the fact that the abnormal discharge acts on both the mental processes ("psych") and the muscles ("motor"). The individual may stop what he is doing and begins some automatic repetitive movement, such as stroking of hair, leg rubbing or pulling at clothing. Chewing movements or repeating short senseless phrases over and over may also occur. During the seizure, the person is not unconscious, but is in a sort of dream state. Afterwards, little or nothing of what happened during the attack will be remembered. This attack may last from two to five minutes, and occur one or more times weekly, monthly or annually.

6. Diseases which can cause epilepsy are meningitis (an inflammation of the membranes that surround the brain) and encephalitis (an inflammation of the brain itself).

7. When someone has a seizure, the first thing you do is clear the area around the person and keep calm.

8. Anticonvulsant drugs are used in the program treatment. It is believed that these drugs work on the nerve cells around the abnormally discharging neurons to make them less excitable.

9. Approximately 4,000,000 persons in the United States are believed to have epilepsy. Eighty percent of the cases are usually seen in the first nineteen years of life. It is believed that the number is far greater, but lack of knowledge and prejudice combined with fear cause the exact number of cases to be unknown.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
EPILEPSY REFERENCE SHEET

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
EPILEPSY HANDOUT

WHAT TO DO DURING A GRAND MAL SEIZURE

1. REMAIN CALM. Students will assume the same emotional reaction as their teacher. The seizure is painless to the child.

2. Do not try to restrain the child. There is nothing you can do to stop a seizure once it has begun. It must run its course.

3. Clear the area around him so that he does not injure himself on hard or sharp objects. Try not to interfere with his movements in any way.

4. Don't force anything between his teeth. If his mouth is already open, you might place a soft object like a handkerchief between his side teeth, and turn him on his side so that the saliva can pour out of his mouth.

5. It isn't generally necessary to call a doctor unless the attach is followed almost immediately by another major seizure, of if the seizure lasts more than about ten minutes.

6. When the seizure is over, let the child rest if he wants to.

7. The child's parents and physician should be informed of the seizure.

8. TURN THE INCIDENT INTO A LEARNING EXPERIENCE FOR THE ENTIRE CLASS. EXPLAIN WHAT A SEIZURE IS, THAT IT IS NOT CONTAGIOUS, AND THAT IT IS NOTHING TO BE AFRAID OF. TEACH UNDERSTANDING FOR THE CHILD - NOT PITY - SO THAT HIS CLASSMATES WILL CONTINUE TO ACCEPT HIM AS "ONE OF THE GANG."

MANAGEMENT OF CHILDREN WITH EPILEPSY

1. Do not pamper the child for fear he will have a seizure.

2. Do not let him "rule the roost."

3. Do not fear or pity him.

4. In general, treat the child with epilepsy as you would any other student. This is essential if the child is to develop a healthy personality, and become a normal, productive member of society.

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EPILEPSY SERVICES
of CHICAGO
22 W Monroe Chicago, Ill 60603
(312) 332-4167

JUST WHAT IS EPILEPSY?

Epilepsy is a sudden discharge of electricity in the brain. It may or may not be traced to actual brain damage. If the electrical discharge covers the entire brain, it is called a "generalized" seizure. If the electrical activity stays in a small area or just a part of the brain, it is called a "partial" seizure.

In generalized seizures, the individual may show a violent shaking of the entire body for two to five minutes. This is sometimes called "grand mal" epilepsy. It is scary, but the person is not in pain. Nor is he in danger of his life. Another generalized seizure that you should especially know about is the "absence" seizure. Here, the individual loses consciousness as if his mind "had gone blank for a while." This kind of epilepsy, sometimes called "petit mal" is often discovered by teachers.

In partial seizures, there may be twitching of just one part of the body such as a hand or an arm. Or, the person may get up, walk around and say and do things that do not fit into what he should be doing at the moment. Most often, they will not remember anything that they did.

EPILEPSY SERVICES of CHICAGO
22 W Munroe Chicago, Ill 60603
(312) 332-4107

A FEW THINGS YOU SHOULD KNOW ABOUT EPILEPSY

A recent report by the National Commission for the Control of Epilepsy and Its Consequences says that everyone should be familiar with the following facts about epilepsy:

- Epilepsy is not a disease. It is a symptom of a disorder of the brain.
- Epilepsy has no single "cause", but can be caused by any number of conditions that injure or effect the function of the brain. Many causes can be prevented.
- Epilepsy can affect anyone, at any age, at any time.
- Epilepsy has many forms, ranging from massive convulsions to momentary lapses of attention, marked only by a blink or random movement.
- Epilepsy is an episodic disability. For the majority, seizures are brief and infrequent. Between seizures, most people with epilepsy are perfectly normal and healthy.
- Epilepsy, for most, can be treated, thus permitting many individuals to lead normal lives.
- Epilepsy can carry with it a host of psychological and social problems--misunderstanding and rejection by family and friends, inability to get a job, insecurity, frustration, anger--that for most victims are more difficult to handle than the actual seizure problem itself.

The report also says that 75% of epilepsy cases occur before the age of 18. Epilepsy affects approximately one child out of every 100. However, any child may have one or more seizures due to a fever or other temporary condition. If your child has a convulsion, do not panic. But be sure to consult a physician or neurologist. Here are some additional facts which should help parents and members of the general public in dealing with this common neurological disorder.

AFFILIATED WITH EPILEPSY FOUNDATION OF AMERICA

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BEHAVIORAL DISORDER OUTLINE

I. Educational Provisions

  A. Congressional Procedures
  B. Public Laws

II. Definition of Behavior Disorders

  A. Terminology Conflicts
  B. Rules and Regulations Prescription

III. Statistical Factors

  A. Prevelance
  B. Persistence

IV. Educational Status

  A. Intelligence Data
  B. Achievement

V. Theoretical Basis

  A. Biophysical Theory
  B. Environmental Theory
  C. Psychodynamic Theory
  D. Behavioral Theory

IV. Conclusion

  A. Educators Role
  B. Implications

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session # 6

Script: Behavioral Disorders

by
Robert Honkisz
Junior High Curriculum Advisor

Prior to 1963 there were no effective programs that rehabilitated people who were handicapped physically, emotionally, and/or mentally.

This situation has since changed dramatically. The reason being that the Congress passed, and President Kennedy signed, into law Public Law 88-164. This law provides for the training of professional personnel to work with handicapped people.

In 1975, President Ford signed into law a provision that a free, appropriate public education be provided for all handicapped children. This law is known as Public Law 94-142 and it is a result of the Education for all Handicapped Children Act of 1975.

Handicapped children are not able to be rehabilitated in special education classes and to receive an education that is equal to that received by normal children.

One group of children able to benefit from these new educational provisions are those handicapped by a behavioral disorder.

There are many definitions for the term behavioral disorder. These definitions vary because educators have different points of view regarding behavioral disorders. Some educators are concerned with behavioral disorders in relation to the child being unable to learn properly while other educators involved with behavior disordered children regard them as suffering from a social maladjustment.

For purpose of this paper, the definition for behavioral disorder given by the State of Illinois will be used. This definition is as follows:

> Behavior disorder - the child exhibits an affective disorder and/or adaptive behavior which significantly interferes with his or her learning and/or social functioning. (Rules and regulations, 1975, p. 13)

The term, affective, disorder, used in this definition for behavior disorder connotes an emotional problem on the part of the child. For this reason behavior disorders has been used interchangeably with the term emotional disturbance.

Just as the definition for behavior disorder is dependent upon the discipline of the educator so also are the estimates for the incidence and persistence of these disorders.

The U.S. Office of Education estimated that there were 1.3 million children between the ages of 0 and 19 years suffering from a behavior disorder. This estimate was made for the 1975-1976 fiscal year.

Another way to represent this estimation is to state that 2% of the population is emotionally handicapped. The highest incidence of behavior disorders occurs at the primary grade level and at the junior high school level.

The research literature on the persistence of behavior disorders has been reviewed by Clarizio and McCoy (1976). The review resulted in the following conclusions:

1) Three out of ten disturbed children would manifest moderate to severe emotional problems as adults.
2) Seventy per cent of the disturbed children would develop into normal adults.
3) The persistence of an emotional handicap appears to be related to its severity and to the number of manifest symptoms.
4) The persistence of an emotional handicap is related to the nature of the disturbance and to the environment in which the individual functions.
5) Severe cases of aggressive antisocial acting-out behavior are generally predictive of adult disturbances.
6) Juvenile delinquency is not strongly predictive of adult criminality.
7) Shyness and withdrawal decrease with age and are not strongly predictive of adult disturbances.
8) Fears, phobias, tics, and the like (neurotic symptoms) are not strong predictors of adult distuobances.
9) Severe emotional disturbances (autism, schizophrenia, and the like) persist in 70% to 75% of cases into adult life.

The occurrence of behavior disorders has also been researched in relation to sex. There is a ratio of 4 boys to 1 girl for the incidence of emotional disturbances.

There is a misconception that children with a behavioral disorder have a low intelligence quotient. This is a falsity. Children with an emotional disturbance are usually of average intelligence. It is the behavior disorder that prohibits these children from using their intelligence potential.

It must also be remembered that IQ tests are culturally biased. A child's race, subculture, socioeconomic status, and written and spoken language affect the results of an IQ test.

Achievement in the classroom is affected when a child has an emotional disturbance. This situation is aggravated when the child is passed from grade to grade without the disorder being remediated.

Educators involved in the remediation of behavior disorders support one of four theories explaining the cause of the disturbance and the approach used to rehabilitate children with behavior disorders.

The Biophysical Theory states that there is a direct relationship between physical defects, malfunctions, and illnesses, and the behavior exhibited by the individual. Professionals and parents concerned with severely emotionally disturbed, learning-disabled, perceptually handicapped, and developmentally disabled children are proponents of this theory. These people believe that tha resultant behavior of an emotionally disturbed child is due to an organic dysfunction. They are divided, however, as to the external environment being an eliciting factor for the undesired behavior, or its being an unimportant consideration for the child's problem.

A second approach to behavioral disorders is the Environmental Theory. This theory takes into consideration sociological and ecological factors. It states that a child's deviant behavior is a result of the society and the environment to which the child must respond. The norms and rules of the society in which the child lives are the determining factors for the child's behavior being either appropriate or deviant. The subculture and socioeconomic status affect the environment to which the child must respond either appropriately or inappropriately.

A major problem with the environmental theory is children being labeled for their deviant behavior. Opponents of this theory believe that labeling causes children to display the deviant behavior expected of them.

Human behavior being the result of a dynamic intrapsychic life within the individual is the basic premise of the Psychodynamic Theory. That each individual has an intrapsychic life was established by Freud as a result of his findings on psychoanalysis.

An individual's personality has three interrelating components. (Put up overhead marked #1.) The first component being called the id. The id is the striving for physical pleasure, and it is an unconscious aspect of the personality due to the contraints placed upon it by the rest of the personality and society. The id says, "Gimmie. I want it. Now!" (Refer to ID example on overhead.)

The super-ego is the second component of personality. Super-ego is a partly conscious and partly unconscious aspect of personality. It is a person's conscience. The super-ego is judgmental being remonstrating and remembering the rules. (Refer to SUPER-EGO example on overhead.)

The third component of personality is the one that acts as moderator between the id and the super-ego. It is the ego. The ego is conscious of reality. A healthy personality has the ego as the decision maker without being overpowered by the id or the super-ego. (Refer to EGO example on overhead. Now remove overhead.)

Failure of children to display adaptive behavior required of them by their environment is due to the overpowering of the ego by either the id or the super-ego.

The approach taken by psychodynamic theorists to remediate a behavior disorder is known as the psychoeducational strategy. The objectives of this strategy are to understand a child's behavior according to psychoanalytic concepts and to remediate the behavior by establishing a relationship with the child in which he/she has a feeling of acceptance and communication. (Put up overheads number two through eight and read them).

A theory stemming from the psychodynamic theory is Transactional Analysis. Transactional analysis uses different terms for the personality's three interrelating components. The id is known as the child, the super-ego as the parent, and the ego as the adult. This theory uses the strategy of making individuals aware of which component of the personality is being manifested when interrelating with other people.

The fourth and most popular theory dealing with behavior disorders is the Behavioral Theory. Proponents of this theory are concerned with what behavior exhibited by an individual is inappropriate. Once the unacceptable behavior is discovered, it must then be determined what can be done to change this undesired behavior. Behavioral theory is best exemplified by the statement: "What you do is influenced by what follows what you do."

Supporters of behavioral theory believe that the cause for a child's behavior is the environment. The displayed behavior, whether it be appropriate or inappropriate, is reinforced by the environment. Actually the behavior is reinforced by the people or events within a child's environment, i.e. parents, teachers, peers, schoolwork, etc..

It is very important for the behaviorist to accept the child as an individual before attempting to remediate the inappropriate behavior. The remedial procedure is to observe the undesired behavior determing the reinforcers in the environment that maintain such behavior. The behaviorist establishes a systematic approach to eliminate the behavior. This approach entails the behaviorist eliminating the reinforcers that maintain the undesired behavior, implementing different reinforcers to change the behavior and monitoring the effectiveness of the remediation. The behaviorist may choose a tact other than using different reinforcers to change behavior. One tact may be to use punishment of the inappropriate behavior while the other tact is to ignore the maladaptive behavior.

Whatever the procedure used by the behaviorist it must be done with consistency, be given enough duration of time to bring about a change, and use reinforcers that are as "natural" as possible.

Some behaviorists believe that behavior is not only learned, but that it can also be due to an organic dysfunction or to hereditary.

No matter which of the four theories an educator supports, the fact remains that a behavior disordered child must be diagnosed as such. The teacher is usually the first person to observe a behavior problem in the child. The teacher refers the child for further observation and testing to a diagnostic team. This team can consist of a physician, a psychiatrist, a social worker and the educator.

Once the child has been diagnosed as being emotionally disturbed it is then determined where the child can best be rehabilitated. Can the child best be served in an educational or clinical setting? Because the severity of a behavior disorder is usually mild to moderate, the educator is the person who implements a remedial procedure to change the inappropriate behavior. This is accomplished through a special education program.

It is, therefore, very important for the educators to remember that they play a prominent role in the child's life as that child develops physically, mentally, and emotionally. (Refer to handouts on summary of screening, diagnostic, and placement processes, and on the Cascade system of special educational services.)

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BEHAVIORAL DISORDERS VOCABULARY LIST

Behavior Disorder - the child exhibits an affective disorder and/or adaptive behavior which significantly interferes with his or her learning and/or social functioning.

Biophysical Theory - there is a direct relationship between physical defects, malfunctions, and illnesses, and the behavior exhibited by the individual..

Environmental Theory - a child's deviant behavior is a result of the society and the environment to which the child must respond.

Psychodynamic Theory - human behavior is the result of a dynamic intrapsychic life within the individual.

Behavioral Theory - the cause for a child's behavior is the environment. Displayed behavior is reinforced by the environment. The environment is the people and tasks confronting the child.

Deno's Cascade - system of special education services available for rehabilitating handicapped children.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BEHAVIORAL DISORDERS FACT SHEET

Public Law 88-164 provides for the training of professional personnel to work with handicapped people.

Public Law 94-142 provides for a free, appropriate education for all handicapped children.

There are numerous definitions for behavior disorders depending upon the context in which the term is used.

The definition for behavior disorder used is the one given by the State of Illinois. The definition reads as follows:

> The child exhibits an affective disorder and/or adaptive behavior which significantly interferes with his or her learning and/or social functioning.

The term emotional disturbance is used interchangeably with the term behavior disorder.

The U.S. Office of Education estimates that there are 1.3 million children between the ages of 0 and 19 years suffering from a behavior disorder. The greatest number of emotionally disturbed children are in the middle grades.

Two per cent of the population is emotionally handicapped.

The highest incidence of behavior disorders occurs at the primary grade level, and at the junior high school level. There is a ratio of 4 boys to 1 girl for the incidence of emotional disturbances.

Children with an emotional disturbance are usually of average intelligence.

There are four popular theories used to justify the causation and remediation of behavior disorders. The four theories are the Biophysical Theory, the Environmental Theory, the Psychodynamic Theory, and the Behavioral Theory.

The teacher is usually the first person to observe a behavior problem in the child. The majority of children with minor behavioral deviations are dealt with by educators.

Diagnosis of a behavior problem is done by a diagnostic team consisting of a physician, psychiatrist, social worker, and the teacher.

The severity of a behavioral disorder is usually mild to moderate.

The teacher is usually the person who implements a remedial procedure to correct a behavioral problem.

Juvenile crime is increasing and becoming more violent.

Most children who are emotionally disturbed fall into the mild moderate category.

Rehabilitation for emotionally disturbed children and adults is costly and it is hard to get into a program.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
BEHAVIORIAL DISORDER REFERENCE SHEET

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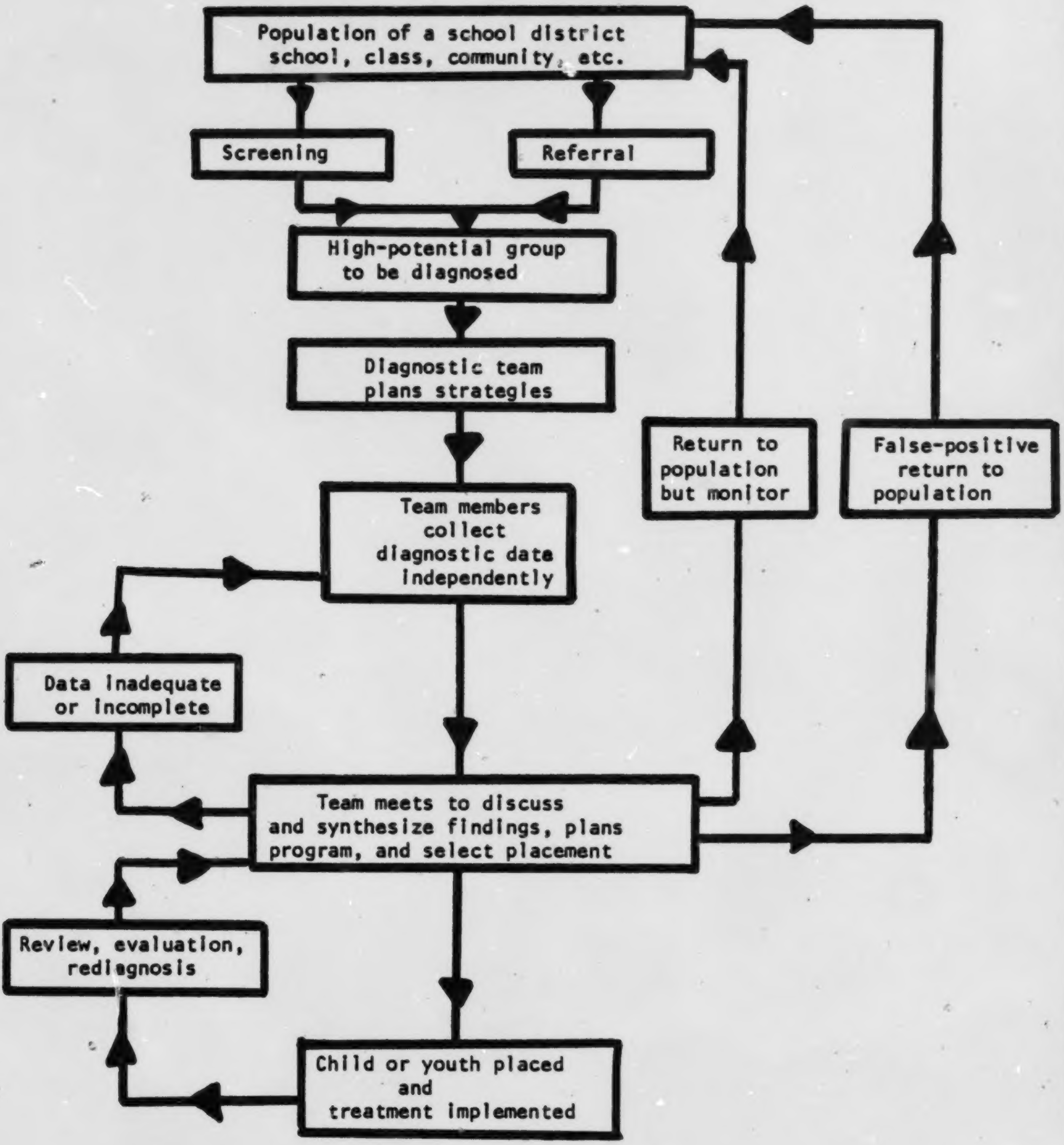
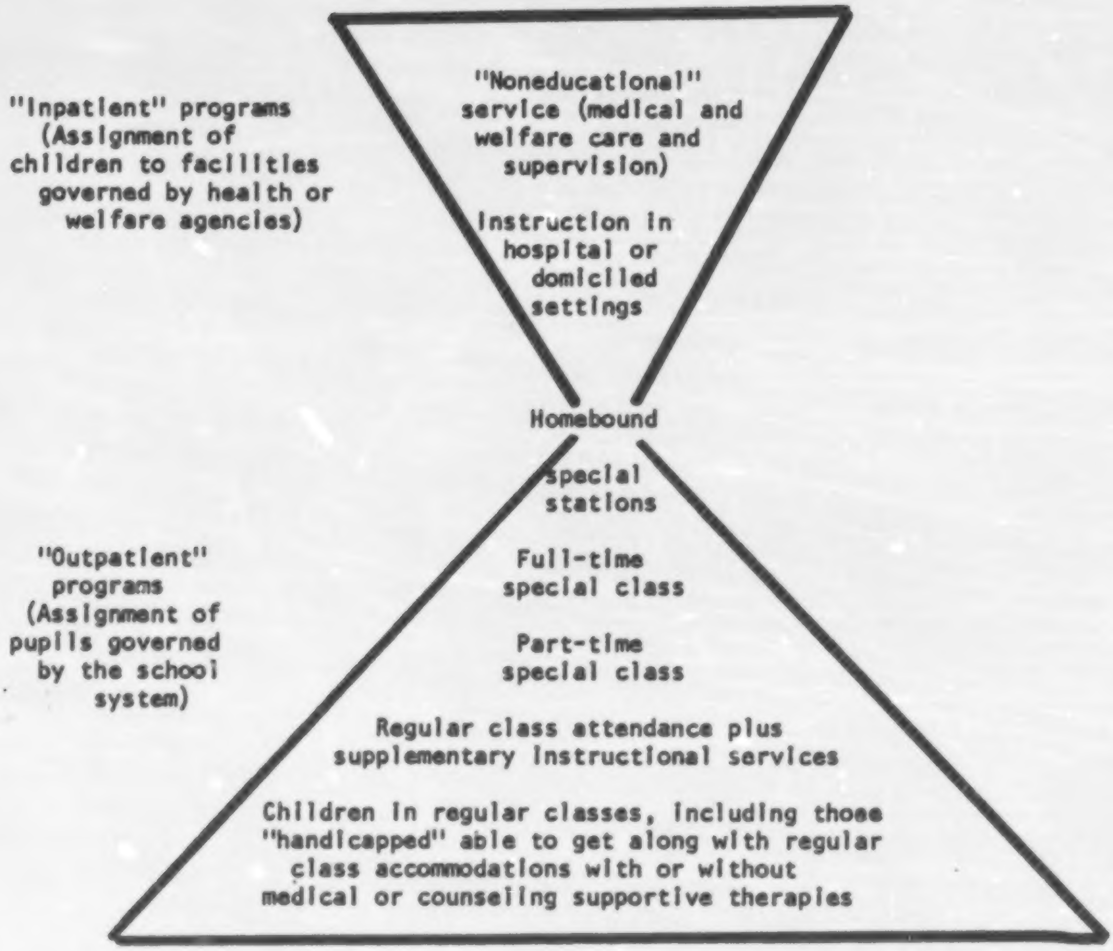

Population of a school district school, class, community, etc.
Screening
Referral
High-potential group to be diagnosed
Diagnostic team plans strategies
Team members collect diagnostic data independently
Data inadequate or incomplete
Team meets to discuss and synthesize findings, plans program, and select placement
Review, evaluation, rediagnosis
Child or youth placed and treatment implemented
Return to population but monitor
False-positive return to population

Summary of screening, diagnostic, and placement processes


"Inpatient" programs (Assignment of children to facilities governed by health or welfare agencies)
"Noneducational" service (medical and welfare care and supervision)
Instruction in hospital or domiciled settings
Homebound
Special stations
Full-time special class
Part-time special class
Regular class attendance plus supplementary instructional services
Children in regular classes, including those "handicapped" able to get along with regular class accommodations with or without medical or counseling supportive therapies
"Outpatient" programs (Assignment of pupils governed by the school system)

Cascade system of special educational services
Reprinted from Deno, E. Exceptional Children, 1970

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
REHABILITATION AND CAREER OUTLINE

I. Definition of Rehabilitation

II. Career Aspects

- A. Professional endeavor of people trained to work with the handicapped.
- B. Occupational possibilities for the handicapped.

III. People involved in rehabilitation

- A. Professionals
- B. Laymen
- C. Handicapped persons

VI. Federal legislation PL 94-142

- A. Implications
- B. Problems

Project C.H.A.N.G.E.
Title IV C
TEACHER TRAINING PROGRAM

Session # 7

Script: Rehabilitation Services and Health Careers

by
Ilona Marmer
Assistant Coordinator

"Rehabilitation" for handicapped persons includes education, medical services, job training and placement: any process that can restore a person and get him into productive activity. By definition, then, this includes "careers" and is impossible to separate from the aspects of handicaps already covered in this workshop.

Two aspects of careers are emphasized in the Project C.H.A.N.G.E. curriculum. The first area covered is professional endeavors of people who are specifically trained to work with or counsel the disabled. The other thrust of career study if the end result of the rehabilitation process: the occupational possibilities for the handicapped.

Rehabilitation and careers are then impossible to separate from each other and from the other topics studied in Project C.H.A.N.G.E. All areas of the curriculum are concerned with restoration (rehabilitation) and daily functioning (careers) of handicapped persons. The handout on "Rehabilitation and Careers" contains a section on each disability in the curriculum. This handout is meant to serve as a reference for all aspects of the curriculum. It covers:

1. Support services
2. Agencies dealing with each disability
3. Devices to aid persons with each handicap
4. Classroom teacher and student accomodations for mainstreaming
5. Career possibilities for each afflicted person

There are many ways to utilize this handout with your students:

1. Research on professionals involved
2. Letter writing to agencies with specific questions or for free information
3. Research and/or demonstration of the devices
4. Role playing with the accommodations for mainstreaming and the career possibilites

People who enable a handicapped person to make this restoration (rehabilitation) fall into three categories and INCLUDE ourselves as teachers:

Professionals - people who have chosen rehabilitation as a career.
Laymen - People who come into contact incidently with helping handicapped individuals.
Handicapped persons - they do much of the restoration and, in fact, have to deal with the most difficult aspects.

The first category is the professionals who work with handicapped persons. These careers are outlined in your handouts and cover the spectrum of medical and social service occupations.

The second category of people who aid in rehabilitating is probably the most interesting because it includes us as teachers: People who are not specifically trained, yet will work in the rehabilitation of a handicapped person to some extent. In time, their category will include more and more people as the handicapped (boosted by federal legislation) become our new radicals. Teachers, some employers, and local government officials are currently in the role of part-time rehabilitator.

As teachers, we must confront the full implication of PL94-142, The Education for All Handicapped Children Act, passed in 1975. We must analyze its benefits and problems. (other legislation effects employers and local governments. I will cover this shortly.)

Let's enumerate the pluses first. This federal legislation is a national commitment to a free and appropriate education for every handicapped child. "Such a serious effort to educate all of a nations handicapped individuals is without precedent in other countries and in the history of mankind."[1] It will affect all of society, but we are on the cutting edge. It is likely to increase our sensitivity before we realize it and this is good. It may force reductions in class size to allow us to meet the needs of students. It may increase employment opportunities.[2]

"The Bureau of Education for the Handicapped estimates that states may need as many as 85,000 new special education teachers in the next two years while colleges and universities are producing only 20,000 such teachers each year."[3]

The problems created by PL94-142 are complex. President Ford summed it up succintly when he signed the bill on November 28, 1975: "This bill promises more than the Federal Government can deliver and its good intentions could be thwarted by the many unwise provisions it contains..."[4] Ford went on to cite specifics such as costly and complex administrative requirements and the possibility of too much federal control over state and local functions.

Translating this into everyday concerns for teachers: Our nitty gritty responsibilities are not at this time spelled out because the federal legislation is so broad. For instance, it does not seem to be expected of us to become experts on the details of each handicapping condition, however, "a teacher does not have to become an audiologist or a speech therapist to help a deaf child improve his speech."[5]

The broad intentions of the legislation include provisions such as:

1. Having each state submit a plan detailing policies and procedures
2. Having local school districts employ additional teachers and related service personnel
3. Having local districts increase inservice programs dealing with IEP's (Individual Educational Programs)
4. Establishing advisory panels to alert state authorities of unmet needs.

"The path from policy to practice has been uneven and not always smooth and we still have a long way to go before the law's numerous provisions are completely realized."[6] When it comes to federal legislation "...much can be lost between the order and the implementation...federal guarantees are highly dependent on the state action...although federal legislation is supposed to apply uniformly throughout the fifty states, one can find great variance in terms of actual services and benefits that people are receiving."[7] The problem seems to be in the interaction of federal and state governments.

Some of the specific problems we have right now are:

1. Lack of funding to do what needs to be done.
2. "Due process guarantees for teachers who are placed in untenable positions due to absence of inservice training and resources."[8]
3. The possibility of short changing other children while attending to the needs of the special child.
4. The reality of labeling a child - it sometimes causes stereotyping and stigmatizing.
5. The correlation of all the special services necessary to mainstream a handicapped child.

The legislative process has taken great steps in PL94-142. Many of the problems will have to be solved by the judicial process. Others will have to be dealt with on the local level. Hopefully, the teaching profession will commit itself to the idea behind PL94-142. Teachers will have to help overcome the problems through their own districts and their unions or professional organizations.

Some future predictions for the implementation of PL94-142 affect teachers directly:

1. There will be negotiated agreements between unions and local school districts reducing pupil teacher ratios to accommodate handicapped students.
2. There will be time provided in the school day to prepare IEP's.
3. There will be more inservice training for classroom teachers in skills needed for mainstreaming.
4. There will be mediation and negotiation involving teachers, parents, education agencies and advocacy groups for the handicapped.[9]

The third category of persons responsible for rehabilitation is the handicapped person himself. Their individual attitudes are crucial in the degree and speed of their restoration. There is much a blind person can do to make his household manageable, just as there are adaptations a wheelchair bound person can make to fit his home to his needs.

The handicapped individual has legal recourse if he feels his rights are being violated. These rights are enforcable by law. Another piece of federal legislation of Title IV and V of the Vocational Rehabilitation Act of 1973. This "Provides mechanisms by which handicapped persons and their advocates may assert rights to employment and access to transportation and public buildings."[10] As with PL94-142 there are enforcement problems. Implementation of the procedures differs from state to state and thus the "fairness" of the act is in question. Organizations of and for the handicapped have recently become very adamant about their rights. They are legally entitled to:

Economic security
A decent standard of living
A meaningful occupation to the extent of their abilities
Family assistance
Residential care as close as possible to normal life

As with PL94-142, little judicial action has been taken to enforce these rights and correct unfairness.

Rehabilitation of handicapped persons is becoming more available through the implementation of federal legislation. Career possibilities for the disabled are increasing because of the same legislation. The letter of the law is clear. The spirit of these laws is evolving and we are now taking part in the evolution.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

HEALTH CAREERS VOCABULARY LIST

The following is a partial list of professions covering all aspects of health.

PROFESSIONAL OCCUPATIONS:

Chiropractor:	treats illness that he believes was caused by interference with the nervous system by manipulating or adjusting specific parts of the body, especially the spinal column. He does not use drugs or perform surgery.
Dentist:	concerned with the care of teeth and associated structures. He is concerned with the prevention, diagnosis and treatment of diseases of the teeth and gums.
Periodontists:	treats diseased tissues that support the teeth.
Prosthodontists:	specializes in making and fitting artificial teeth or dentures.
Pedodontists:	specializes in children's dental problems.
Oral pathologists:	treats diseases of the mouth.
Public Health Dentist:	deals with treatment and education of the public regarding the importance of dental health and care through public health agencies.
Dietician:	scientifically trained in dietetics (including nutrition.
Medical records librarian:	keeps medical records and reports of patients admitted to hospitals.
Optometrist:	examines and determines the condition of one's eyes and prescribes treatment to conserve or improve vision without the use of medicine, drugs or surgery.

Osteopathic physician:	deals in manipulative procedures for the detection and correction of disorders and affections of the bones, muscles, nerves, blood vessels, and other tissues of the body structure. Also, he may be qualified to practice obstetrics, surgery or internal medicine.
Pharmacist:	a druggist; one licensed to prepare and dispense drugs.
Physician:	diagnoses, prescribes medicines for, and otherwise treats diseases and disorders of the human body. He may also perform surgery and operations and he often specializes in one aspect of medical care and treatment.
Podiatrist:	(chiropodist) is one who treats foot disorders.
Psychologist:	One who is trained in methods of psychological analysis, therapy and research.
Registered nurse:	a graduate nurse who has been registered and legally licensed to practice.
Rehabilitation counselor:	interviews and advises physically or mentally handicapped people so they may evaluate themselves in relation to the kind of work that is suitable to his physical and mental capacity, interests, skills, and talents. He usually works in a state agency or institution and works with doctors, nurses, psychologists and others in the medical and health service professions.

SEMI-PROFESSIONAL AND TECHNICAL OCCUPATIONS:

Dental hygienist:	administers dental treatment, gives instructions on teeth care, may take X-rays, and assists the dentist in routine tasks.
Dental laboratory technician:	prepares composition plates from wax impressions, which were formerly done by a dentist. He may also construct metal clamps, inlays and bridgework according to dentist's specifications.
Medical technologist:	performs medical duties in a hospital or laboratory. He makes lab tests of urine, blood, blood counts, spears, prepares vaccines, etc.
Medical X-ray technician:	(technologist), specializes in the use of X-rays,

	radium, and radioactive isotopes in the diagnosis and treatment of disease. Work is done under the general direction of physicians who are usually radiologists.
Occupational therapists:	following physicians instructions, select and direct educational, vocational and recreational activities designed to restore maximum function to mentally or physically disabled patients.
Physical therapist:	treats disorders such as fractures, sprains, nervous diseases and heart trouble, as prescribed by a physician using all of the therapeutic arts. He gives exercises designed to correct muscle ailments and deficiencies to patients, administers massage, and other body manipulations.

SKILLED OCCUPATIONS:

Optician:	fits eyeglasses and adjusts them to the client's comfort.
Recreation therapist:	makes sick people well through participation in therapeutically beneficial recreational activities such as athletics, games, dancing, music, dramatics, gardening, handicrafts, etc.
Speech Pathologist and Audiologist:	helps communication handicapped people and helps them learn to talk and hear as normally as possible (stutter, lisp, cleft-palate, stroke victims, cerebral palsy, etc.)

PROJECT: C.H.A.N.G.E.
Title IV C
REHABILITATION AND CAREERS FACT SHEET

Definition of Rehabilitation -- any process that attempts to restore a disabled person and steers him toward productive activity.

Scope of Rehabilitation - education, medical services, job training and placement.

Three categories of Rehabilitators:

1) Professionals - people who have made rehabilitation their career.

2) Laymen - people who come into contact with a disabled person incidently (family, friends).

3) Handicapped person themselves (they do the hardest work).

Teachers are becoming "rehabilitators" as PL94-142 spreads its influence.

Title IV and V of the Vocational Rehabilitation Act of 1973 "provides mechanisms by which handicapped persons and their advocates may assert rights to experiment and access to transportation and public buildings."

Current status: Little judicial action has been taken, but handicapped groups are becoming more vocal. They are our new radicals.

PL 94-142 - Federal legislation stipulating that all handicapped children are entitled to a public education in the least restrictive environment.

Ideally, PL 94-142 - would be implemented with adequate support services to meet the special needs of handicapped children.

Realistically, implementing PL 94-142 has been problematic. Support services (resource teachers, therapists, etc.) and inservice education have not been what they should be.

FOOTNOTES

1. Galloway, James R. et. al. "Education for all Handicapped Children: Present and Future," Education Unlimited, December, 1979. p. 6.
2. National Education Association.. "PL94-142 and Teachers," Today's Education, November-December, 1977, p. 566.
3. Galloway, p. 8. Ibid
4. Galloway, p. 6. Ibid
5. Yearbook of Special Education 1978-79, Marquis Academic Media, p. 148.
6. Galloway, p. 6. Ibid
7. Yearbook of Special Education 1978-79, p. 576. Ibid
8. National Education Association, P. 566.
9. Galloway, p. 10. Ibid

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
REHABILITATION SERVICES & HEALTH
CAREERS REFERENCES

1. Galloway, James R. et. al. "Education for all Handicapped Children: Present and Future," Education Unlimited, December, 1979. p.6., p. 8, p. 10.

2. National Education Association. "PL94-142 and Teachers," Today's Education, November - December, 1977, p. 566.

3. Yearbook of Special Education 1978-79, Marquis Academic Media, p. 148, p. 576.

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

REHABILITATION AND HEALTH CAREERS

I. BLINDNESS AND VISUAL IMPAIRMENT.

A. SUPPORT SERVICES:

1. Opthamologist - physician for diagnosis and treatment of defects and diseases.
2. Optomotrist - non-medical career, measures irregularities in shape or size of eyeball and eye muscle.
3. Optician - grinds lenses and makes glasses.
4. Surgeon - realigns imbalanced muscles or may reverse loss of sight.
5. Teacher of the Blind - specially trained educator.

B. AGENCIES: (Write for information).

1. Visually Handicapped Managers of Illinois, Inc.
   General Office
   53 West Jackson Boulevard
   Chicago, Illinois

2. Chicago Lighthouse for the Blind
   1850 W. Roosevelt Road
   Chicago, Illinois

3. American Foundation for the Blind, Inc.
   500 North Michigan Avenue
   Chicago, Illinois 60611

4. Hadley School for the Blind
   700 Elm Street
   Winnetka, Illinois 60093

5. Helen Keller National Center for the Deaf and Blind
   Youth and Adult
   111 Middle Neck Road
   Sands Point, N. Y. 11050

6. Illinois Braille & Signt Saving School
   658 East State Street
   Jacksonville, Illinois 62650

C. DEVICES:

1. Seeing Eye Dog
2. Cane
3. Braille writter, slate, stylus or typewriter

D. CLASSROOM TEACHER AND STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Provide verbal descriptions instead of visual clues
2. Accompany a verbal order with a guiding touch.

E. POSSIBLE CAREERS: (Not a complete list, good topics for discussion)

1. Automobile Salesman
2. Assembly Work
3. Insurance Broker
4. Radio Announcer
5. Telephone Sales
6. Typist

II. DIABETES

A. SUPPORT SERVICES:

1. Physician - general practitioner
2. Internist - physician who deals with diseases not usually treated surgically.
3. Metabolic Specialist - physician concerned with metabolism problems.

B. AGENCIES: (Write for information)

1. American Diabetes Association
18 East 48th St.
New York, N.Y. 10017

2. American Diatetic Association
620 N. Michigan Avenue
Chicago, Illinois 60611

3. Diabetes Association of Greater Chicago
8 South Michigan Avenue
Chicago, Illinois

C, DEVICES

1. Diet
2. Insulin
3. Exercise
4. Other medications

D. CLASSROOM TEACHERS & STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Watch food intake
2. Activities usually not limited unless condition is uncontrolled

E. POSSIBLE CAREERS:

1. Can do anything

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III. DEAFNESS

A. SUPPORT SERVICES:

1. Otorhinolaryngologist - eye, ear, nose and throat physician.
2. Audiologist - non-medical, performs hearing tests with audiometer.
3. Speech Pathologist - teaches communication skills, (lip reading, sign language, articulation).
4. Teacher of the deaf - specially trained educator
5. Hearing aid dealer - (sells hearing aids).

B. AGENCIES: (Write for Information)

1. National Association of the Deaf
   814 Thayer Avenue
   Silver Springs, Md. 20910

2. Easter Seal Society
   2023 West Ogden Avenue
   Chicago, Illinois 60612

3. American Hearing Society
   817 Fourteenth Street
   Washington, D. C. 20000

4. Chicago Hearing Society
   178 W. Randolph St.
   Chicago, Illinois 60601

5. Illinois School for the Deaf
   Jacksonville, Illinois 62650

6. Illinois Association of the Deaf
   515 Adams St.
   Elgin, Illinois 60120

C. DEVICES:

1. Hearing Aids
2. Hearing Dogs

D. CLASSROOM TEACHER & STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Learn how to replace batteries in hearing aids and have family supply an extra to be kept in the classroom.

2. Speak clearly and directly to child.

3. Speak in short simple sentences.

4. Use mainly nouns and action verbs.

E. Possible Careers: (Not complete list, good topics for discussion.)

1. Architect
2. Machine Operator
3. Bookkeeper
4. Artist
5. File Clerk
6. Engineer

IV. SPEECH IMPAIRMENTS:

A. SUPPORT SERVICES:

1. Speech Pathologist - specially trained person who remediates organic and functional speech problems.
2. Audiologist - non-medical, performs hearing tests with audiometer.
3. Orthodontist - corrects organic dental problems.
4. Surgeon - surgically treats organic defects (cleft palate, etc.)

B. AGENCIES: (Write for information)

1. American Speech & Hearing Association
   10801 Rockville Pike
   Rockville, Maryland 20852

C. DEVICES:

1. Oral prosthetic device
2. Hearing aid
3. Palate spacer or bar

D. CLASSROOM TEACHER & STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Refrain from embarrassing the child by correcting him in front of others.
2. Know the sounds the child is working on.

E. POSSIBLE CAREERS: (Not a complete list, good topics for discussion)

1. Can do anything with the exception of careers that require public speaking (radio announcer, etc.)
2. Speech impairment can be an asset in the entertainment field.

V. EPILEPSY

A. SUPPORT SERVICES:

1. Physician - can diagnose, treat or refer and maintain.
2. Neurologist - a specialist in diseases of the nervous system.
3. Dietician - helps patient plan meals and form proper eating habits.

B. AGENCIES (Write for information)

1. Epilepsy, Chicago Metropolitan Chapter
   22 West Monroe
   Chicago, Illinois

2. Moraine Valley Epilepsy Self-Help Group
   Moraine Velley Community College

C. DEVICES:

1. Medication - different varieties according to diagnosis

D. CLASSROOM TEACHER & STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Child can do anything others do
2. Teachers should know First Aid for seizures

E. POSSIBLE CAREERS:

1. Can do anything but sometimes have problems being hired.

VI. PHYSICAL HANDICAPS

A. SUPPORT SERVICES: The wide variety of medical problems requires a wide variety of specialists:

1. Physician - diagnoses and refers, treats and maintains.
2. Osteopath - a physician who uses manipulative corrections of the bony framework.
3. Orthopedic surgeon - repairs, reconstructs, treats.
4. Industry - manufactures and sells appliances.
5. Physical Therapist - teaches proper use of working muscles. Works with mobility.
6. Occupational Therapist - teaches and directs careers and rehabilitation. Helps with leisure time.
7. Speech Therapist - corrective work with speech problems resulting from handicap.

B. AGENCIES: (Write for Information)

1. Division for the Blind & Physically Handicapped
   The Library of Congress
   Washington, D. C. 20542

2. Rehabilitation Institute of Chicago -
   345 E. Superior St.
   Chicago, Illinois

3. Easter Seal Society for Crippled Children & Adults
   2023 West Ogden Avenue
   Chicago, Illinois 60612

4. American Occupational Therapy Association
   250 West 57th St.
   New York, N. Y. 10019

5. Association for the Aid of Crippled Children
   345 East 46th St.
   New York, N. Y. 10017

C. DEVICES:

1. Braces
2. Artificial Limbs
3. Special shoes
4. Wheelchair
5. Crutches
6. Canes
7. Walkers
8. Bookracks for children who cannot hold books
9. Typewriters for children who cannot control movement.
10. Specially adapted pencil holders

D. CLASSROOM TEACHER & STUDENTS ACCOMMODATIONS FOR MAINSTREAMING:

1. Make provision for mechanical equipment (wheelchairs, crutches, etc.)
2. Be aware of dangers for children who are not mobile or who are unsteady on their feet.
3. Check to see that the child can use bathroom facilities
4. Assign a buddy for needed assistance

E. POSSIBLE CAREERS (Not complete list, good topics for discussion)

1. Accountant
2. Architect
3. Computer Programmer
4. Teacher
5. Secretary
6. Pharmacist

VII. MENTAL RETARDATION

A. SUPPORT SERVICES:

1. Childcare
2. Surgeons - make necessary corrections
3. Vocational training - work with mentally retarded in career training.
4. Psychologist - diagnoses and treats emotional problems
5. Teachers of Special Education
6. Social Workers - eliminate environmental problems
7. Nurse - treats - instructs and care for.
8. Counselor - recommend possibilities for the future
9. Neurologist - diagnose and treat problems involving the nervous system.

B. AGENCIES: (Write for information)

1. National Association for Retarded Children
2709 Avenue E East
Arlington, Texas 76011

2. American Association on Mental Deficiencies
5101 Wisconsin Agenue, NW
Washington, D. C. 20016

3. Chicago Association for the Retarded
343 So. Dearborn
Chicago, Illinois

4. Chicago School and Workshop for the Retarded
The Bryon Center
6050 N. California Ave.
Chicago, Illinois

5. Illinois Association for Retarded Citizens
6 North Michigan Avenue
Chicago, Illinois 60602

6. President's Council on Mental Retardation
Washington, D. C. 20201

C. DEVICES:

None applicable unless another handicap present

D. CLASSROOM TEACHER AND STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

(Mostly into grade levels two to three years behind).

1. Treat as normally as condition permits
2. Provide extra and special help
3. Help establish acceptable social behavior

E. POSSIBLE CAREERS: (Not complete list - good topics for discussion)

1. Carpenter
2. Domestic work
3. Machine operator
4. Gardener

VIII. LEARNING DISABILITIES

A. SUPPORT SERVICES:

1. Pediatrician - to diagnose, treat and refer
2. Neurologist - to diagnose and treat disorders involving nervous system (often resulting from brain injury)
3. Psychiatrist - to work with learning disabled person on emotional problems
4. Opthalmologist - diagnose or treat eye defects
5. Training programs - coordinate action of eye, hand or brain
6. Learning Disabilities Teacher - specially trained educator

B. AGENCIES: (Write for Information)

1. Association for Children with Learning Disabilities
4156 Library Rd.
Pittsburgh, Pa. 15234

2. Illinois Council for Children with Learning Disabilities
P.O. Box A3239
C Chicago, Illinois 60690

3. Chicago Association for Children with Learning Disabilities
Box 42888
Chicago, Illinois 60642

4. Orton Society
8415 Bellona Lane
Towson, Md. 21204

C. DEVICES:

1. Physical exercises for sensory-motor coordination
2. Three dimensional models (of letters, for example)
3. Drug therapy

D. CLASSROOM TEACHER AND STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Be aware of discrepancies in growth that demonstrate learning disabilities
2. Provide special and extra help when necessary

E. POSSIBLE CAREERS (Not complete list, good topics for dicsussion)

1. Can function in any capacity as long as they can compensate.

Discuss:

a. Nelson Rockefeller
b. Lucy Baines Johnson
c. Winston Churchill

IX. EMOTIONAL PROBLEMS

A. SUPPORT SERVICES:

1. Physician - diagnose, treat and maintain and refer. Can prescribe drug therapy
2. Psychologist - a medical doctor specializing in areas of emotional disturbance
3. Psychiatrist - to diagnose and treat behavior disorders
4. Social worker - recommend placement and eliminate environmental problems.
5. Guidance Counselor - School personnel who help children sort out problems.
6. Residential School - only in severe cases.

B. AGENCIES: (Write for information)

1. American Institute of Family Relations
5287 Sunset Blvd.
L. A., Calif. 96327

2. Mental Health Association
1800 N. Kent St.
Arlington, Virginia 22209

3. National Institute of Mental Health
Printing and Publications Section
5600 Fisher Lane - Rm. 6-105
Rockville, Md. 20857

4. Pritzker Medical Center
950 East 59th St.
Chicago, Ill.

C. DEVICES:

1. Drug Therapy

D. CLASSROOM TEACHER & STUDENT ACCOMMODATIONS FOR MAINSTREAMING:

1. Be aware of signs of emotional problems
2. Know school system of referral
3. Know strong channels so work can be presented appropriately

E. POSSIBLE CAREERS:

1. Can do anything that doesn't disrupt emotional balance. Discuss possiblities:
   a. Teaching
   b. Secretarial work
   c. Public relations
   d. Assembly line jobs
   e. People related work versus isolation situations

Seven Principles of P. L. 94-142

Principle of Zero-Reject/Child Find. A school system can no longer exclude a handicapped student from a public education because of the specific nature or degree of his/her handicap, e.g., physical, emotional, mental. All individuals who have been excluded in the past and are within state compulsory school age limits must be located and provided with appropriate educational services. All states are required to implement child guardians of available programs.

Principle of Nondiscriminatory Testing. Students who are being considered for specialized services must be evaluated by a multidisciplinary team including at least one teacher or specialist with knowledge in the area of the specific disability, e.g., physical therapy, resource consulting. Tests or assessment instruments must be administered in the child's native language or other mode of communication, e.g. manual signs, communication boards. Furthermore, testing instruments must be validated for the specific purpose for which they are used and tailored to assess specific areas of educational need and not merely those which are designed to provide a single general intelligence quotient. In addition, no single test can be used as the sole criterion for determining placement into a special education program. Additional methods of evaluation particularly for severely handicapped individuals would include observations of the student in his/her natural environment, i.e. at home, in the classroom or playground, to better assess current skill levels.

Principle of Individual Education Programs (IEP). For each handicapped student, a written statement must be developed and implemented which includes a) a statement of the student's present level of educational performance, b) a statement of annual goals including short-term instructional objectives, c) a statement of specific education and related services to be provided to the student and the extent to which the student will be able to participate in regular educational programs, d) the projected dates for initiation of services and the anticipated duration of services, and e) appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved.

Principle of Least Restrictive Environments. To the maximum extent appropriate, handicapped students, including children in public or private institutions or other care facilities, are to be educated with children who are not handicapped. Special classes, separate schooling, or other segregation of handicapped children from the regular educational environment can occur only when the nature or severity of the handicap is such that education in regular classes or facilities with the use of supplementary aides and services cannot be achieved satisfactorily. In addition, a continuum of alternative placements must be available to meet the needs of handicapped children for special education and related services, i.e. instruction in regular classes, resource consulting, special classes, special schools, home instruction.

Principle of Procedural Due Process. Parents of handicapped children must be given prior notice of a preplacement evaluation and for the initial placement of a student in a program providing special education and related services. The notice must include a full explanation of all procedural safeguards available to the parents, e.g., impartial due process hearings, a description of action proposed or refused, the specific reason for the action, and a description of the evaluation procedures. The notice must be written in language understandable to the general public and provided in the native language of the parents. Written consent must be obtained from the parents before any action is taken to hold an evaluation or place the student in special education programs.

Principle of Parent Participation. Parents must receive written notice in their native language whenever an educational agency proposes to evaluate their child, identify him/her as handicapped or change the educational placement. Parents are able to participate in placement and programming meetings and to have an impartial due process hearing if they are not in agreement with the decisions resulting from the above procedures. They additionally have the right to inspect and review any educational records relating to their child.

To insure that these rights are upheld, the school district must: 1) obtain parental consent in writing prior to a formal evaluation, 2) insure that the multidisciplinary staff conference is held at a time and place that allows parental participation, and 3) assist parents in taking whatever steps are necessary to utilize the hearing process if they are not in agreement with the decisions reached concerning their child's educational placement.

Principle of Appropriate Education. All handicapped students must be provided with appropriate services, personnel, and facilities necessary to meet full educational opportunities. In regard to severely handicapped students this would include: appropriate student-teacher ratios, appropriate age ranges within classrooms, normal school day hours, interactions with nonhandicapped peers, adequate supportive staff, e.g., physical, occupational, and speech therapists, appropriate and adequate materials and equipment, functional curriculum content, data based instruction, and transportation services.

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PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

TYPES OF MAINSTREAMING

TYPE	REQUIREMENTS	PURPOSE
Academic or Educational	The child must be functioning at the appropriate grade level on the topic area when mainstreaming is to occur.	To let the child experience educational interaction with peers who will later be competitors in the application of education (functioning in life).
Areas:	Math, Reading, Spelling, Social Studies, Health, Language Arts	
Social/Emotional	The child must be functioning at the appropriate social/emotional age level and behavior must not be a source of disruption	To develop the skills of communication and group interaction at a socially acceptable level
Areas:	Art, Music, Library Club Activities, Performances	
Physical	The child must have a physician's note prescribing physical education (and it's limits) into either a regular or adoptive class.	To experience as many different physical activities (as possible) so the individual can understand their physical performance in terms of their own emotional and mental make-up during a given task or skill.
Areas:	Physical Education, Recess	

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SOME TIPS FOR SUCCESSFUL MAINSTREAMING

DISABILITY	MOBILITY	SEATING	DEVICES & AIDS TO LEARNING	OTHER
Deafness	none	close to teacher for lip reading. Roving privileges allowed Try to stay directly in front of child when speaking	Hearing aid loop system Finger spelling sign language use visual aids where possible Explain new vocabulary prior to lesson	Buddy system of peer tutoring Maintain close contact with deaf education teacher
Blindness	child must be thoroughly familiarized with physical layout of room prior to integration	situated so as to allow clear access to all classroom activities and door	Tape recorder slate & stylus Braille materials	Buddy system of peer tutoring Allow child to demonstrate materials and equipment to class Maintain close contact with teacher of blind
Physical Handicaps	wheelchair will need space with adjustable desk top	situated so as to allow easy access to classroom activity centers and door in case of emergency	may need pen holder, chalk holder, automatic page turner	maintain close contact with physical therapist
Speech Impairments	none	none	Reinforce childs speech by praising efforts Do not interrupt or hurry child Provide appropriate model for imitation	Provide regular opportunities for speech See that child has regular contact with therapist

DISABILITY	MOBILITY	SEATING	DEVICES & AIDS TO LEARNING	OTHER
D[illegible]etes	none	none	Become familiar with childs medical regimen Become familiar with warning signs of diabetic reactions	Develop and rehearse emergency plan.
Epilepsy	none	none	none	Become familiar with warning signs. Explain problem to class Develop plan in case seizure occurs
M[illegible]l R[illegible]rdation	none	Close to teacher for assistance in following directions and on task	Keep language simple Demonstrate wherever possible short carefully sequenced lesson	Maintain contact with Special education teacher.
Learning Disabilities	none	close to teacher for assistance	Provide quiet space. Tape recorder utilize auditory or visual approach where appropriate. Establish routine and follow it.	Maintain contact with LD teacher

D[illegible]BILITY	MOBILITY	SEATING	DEVICES & AIDS TO LEARNING	OTHER
Emotional problems	none	close to teacher Contiguous to appropriate student models of good behavior	Provide clear understanding of behavioral limits Establish routine and stick to it. Establish reinforcement system	Rely upon social worker and/or psychologist for difficult problems

AMERICAN FEDERATION OF TEACHERS
NEWSPAPER LOCAL 943

COPING WITH PUBLIC LAW 94-142

As those of you who are special ed teachers know, there are several snags in P.L. 94-142. For instance, the amount of time required to prepare Individualized Education Programs along with other reporting tasks, cuts into instructional time. The problem with this law is further aggravated by the gross underfinding of the statute. Most public school systems are attempting to implement this law at a time when they are experiencing major financial crises. Teachers have been told by costconscious administrators that they cannot include certain mandated services on the IEP because they are not available in the school district nor can the system afford to provide them. Such ommissions compromise teachers in carrying out their professional responsibilities, the teachers who forcefully argues for appropriate services can be considered insubordinate.

At the 1979 AFT convention, these concerns culminated in the adoption of a special order of business on P.L. 94-142 by the 2500 assembled delegates. While the AFT supports the objective of providing effective educational services to P.L. 94-142, they are categorized in the resolution as follows: 1) the federal mandate requires the expansion of expensive services to handicapped children without supplying adequate funding, thereby necessitating cutbacks in services to nonhandicapped students; 2) the increased paperwork resulting from the IEP, reduced child-teacher contact (instructional) time; and 3) the "less restrictive environment" mandate has frequently resulted in wholesale mainstreaming, often without the teacher being informed of the special placement and almost always without the teacher receiving adequate training prior to the placement, and with all children, both handicapped and nonhandicapped, being unprepared for the transition. The policy statement resolves that AFT notify HEW, Congress, and the president of these concerns, that an investigation be demanded and immediate action taken to correct abuses of handicapped childrens' rights to an appropriate education. The resolution further states that if corrective action is not taken, the AFT will seek to suspend these sections of P.L. 94-142 responsible for diminishing the quality of education handicapped children receive, while at the same time working to ensure that "local school programs for handicapped children and the federal monies adhering to these programs continue." The AFT calls on the federal government to: 1) provide every dollar of new monies needed to implement the mandates; 2) make sure all teachers and para-professionals who are or will be teaching "mainstreamed" students have the opportunity to complete the necessary professional inservice training; and 3) conduct a study of the full effects of P.L. 94-142 on handicapped students and nonhandicapped students and its impact on the structures of state and local school district financing be conducted and made available to Congress (before it acts to restore the P.L. 94-142 mandate).

Illinois School Journal
Spring/Summer, 1979

Mainstreaming: Its Implications

Earl J. Ogletree

The concept of "normalization" or "mainstreaming" in the educational placement of handicapped children today is much in vogue. This concept is interpreted as the integration of educable mentally retarded (EMR) children into groups of nonretarded children, with the intent of minimizing their distinctiveness or differences. Mainstreaming has as its objective to provide children with the most appropriate and effective educational experiences which will enable them to become self reliant adults. Now that a basic concept of what mainstreaming is has been presented, it is the intent of this paper to provide its readers with an awareness and understanding of the implications of such a plan.

Mainstreaming, although new as a movement, is not new in practice. It has been estimated that approximately 50% of the 8 million handicapped children are receiving education in regular classrooms. This may have been the result of the school systems' inability to provide special services. It is feared by many educators that because of the pressing circumstances of shrinking budgets, the "ideal" form of mainstreaming will be replaced by an inferior expediency. Such an expediency would suggest the inclusion of all but the most severely handicapped children in regular classrooms without adequate consideration of the impact on the classroom or teacher and without the provision of support services. It is feared that those persons most able to provide essential support services, the special educators, will be laid off by local educational agencies that will unwisely force mainstreaming.

With the inclusion of handicapped children in the regular classroom, the role and responsibilities of the teacher will be greatly changed. Educators will need to exercise a wide range of skills, many of which will not have been required in the teacher's previous classroom experience. Children with the types of handi-

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caps the teacher may be required to deal with may include the mildly retarded, physically handicapped, learning disabled, speech and hearing impaired, visually impaired, and emotionally disturbed. In addition, many of those included in the "normal group" may have handicaps that require special attention.

It is the intention of mainstreaming to maximize interactions with nonhandicapped students. This transition may produce hazards and misgivings for all concerned, including the teacher. Accustomed to a great deal of individual attention, some handicapped individuals may have misgivings about their integration; on the other hand, the nonhandicapped, unaccustomed to interacting with the handicapped, may have anxiety and be less accepting. In practice, the daily responsibility falls on the teacher. Although regular classroom teachers may have had some training in the education of the handicapped, many will not have the expertise to prescribe learning experiences for them all. On the other hand, special educators will have had extensive experience in programming for handicapped children but will now be dealing much less often with handicapped students in a segregated setting. It is necessary now for a new relationship between the regular educator and the special educator be developed, a partnership based upon the sharing of expertise and directed toward the most effective programming for individual students. The most immediate training needs for classroom teachers include the development of understanding how a handicap affects learning, skill in recognizing handicaps, prescriptive teaching, skill in behavior management techniques, understanding of and ability to respond to the emotional needs of handicapped children, and development of a new, working relationship between special and regular educators.

On the federal level, both the Bureau of Education for the Handicapped (BEH) and the Teachers Corps are addressing the new relationship between special and regular educators by emphasizing inservice training. A significant start has been made toward the revision of teacher curriculums. These federal efforts are well directed because a great number of teachers either are or soon will be facing handicapped children in the regular classroom. The Education for All Handicapped Children Act requires each state to provide training for virtually all teachers with any responsibility for the handicapped. It appears that the retraining of every public school teacher is quite inprobable and surely to be expensive. Supposedly the funds required for such an effort are not available. If these needs are to be met, a greater commitment of resources and coordination at all levels will be required. It isn't that teachers are unwilling to teach the handicapped, but they want the special training and support services to meet the needs of the students who will require "special" treatment.

If mainstreaming is to be successful, certain recommendations need to be considered. First are the conditions of mainstreaming. The educational rights of all students must be protected. This requires that all programs be closely monitored to guarantee complete educational services for the handicapped without reducing the educational opportunitits for others. Adequate funds must be provided for teacher preparation, for appropriate materials, and for supportive pupil personnel services. The states considering mainstreaming must study it and its alternatives and strictly define the conditions under which mainstreaming will be permitted (the child's needs, class size, supporting services, preparation of staff, procedural safeguards).

Another consideration is the continuation of BEH and Teacher Corps programs emphasizing both skills acquisition and leadership development. Local and state education agencies must be aware of opportunities for federal assistance. Emphasis should be put on the training of all three groups together: administrators, special, and regular educators. Hopefully this would help dissolve unnecessary barriers between special and regular education and facilitate coordination. Strong emphasis should be put on the continued evaluation and revision of teacher education curriculum. The most promising developments in teacher curriculum for personnel to work with handicapped children should be disseminated to state certification officers and decision makers in other institutions of teacher preparation. Investigations into the feasibility of several types of widespread delivery systems for inservice training, including instructional television and standardized materials, need to be made. In addition all relevant federal sources should be coordinated to provide teachers and school systems with materials, information, and consultation which will increase their capacity to serve handicapped children. Finally, regional conferences which aim at the examination and rapid revision of certification requirements to include training in the education of the handicapped are necessary.

The school systems, state governments, and the federal government have a responsibility to provide all children with a free, appropriate education. Currently, the needs are growing much more rapidly than are our abilities and resources to meet them. To insure a quality education for all children, leadership must be exerted at all levels.

PRESENTING SESSION #8

The most effective way to implement the Presentation of Curriculum session is by presenting the information in the script to the teachers in one large group. After this information has been presented it is advisable to divide into three small groups (primary, intermediate and junior high).

In each group a designated staff member will review the Teacher Manual with the teachers. Upon entering the session the teachers are to receive their grade level copy of the manual. It is advisable for staff members to go through the manual looking at each unit and answering any questions which might arise about the program.

Please note the overhead transparencies and additional information behind the script which should be explained before entering small group sessions if the district is participating in either evaluations, assessment instruments or both. It is recommended that this information be relayed to the group as a whole.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

PRESENTATION OF CURRICULUM OUTLINE

I Curriculum Units

- A. Primary
- B. Intermediate
- C. Junior High

II Curriculum Timelines

III Teacher's Manual

- A. Format
- B. Lesson Plans - Activities

IV Material Storage

- A. Bibliography Cards
- B. Resource File
- C. Teacher Training Program

V Readability

- A. Grade Level
- B. Terminology

VI Special Education Classes

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA
TEACHER TRAINING PROGRAM

Session #8

Script: Presentation of Curriculum

by
Karen Harper
Primary Curriculum Advisor
and
Mary S. Smith
Coordinator

The previous training sessions have focused on various handicapping conditions for the purpose of providing background information. This session illustrates the presentation of this information to the students. The Project C.H.A.N.G.E. Curriculum is a guide for educating todays students about disabilities.

The curriculum is divided into three levels: Primary, Intermediate, and Junior High. Comprehensive programs for each grade are found within these levels. Each grade (kindergarten through third) in the Primary Level studies seven topics: (Show Overhead #1) Normal Health, Senses, Acceptance of Individual Differences, The Disabilities of Blindness, Deafness, and Physical Handicaps, and as a conclusion The Acceptance of Handicaps. The units on Normal Health and the Senses are placed first to provide the students with a background for better understanding handicapping conditions. Similarly, the unit on Acceptance of Individual Differences precedes the disability units based on the premise that in order to accept others people must first accept themselves. Blindness, Deafness and Physical Handicaps are studied at the Primary Level because these are the three most observable handicapping conditions and concrete information is more easily understood by students at the primary level. The concluding unit, Acceptance of Handicaps is the very essence of the program. This is what it's all about - acceptance of handicapped people.

(Show Overhead #2a) At the Intermediate Level the first unit studied in each grade is Acceptance of Self and Others (Handicapped and Non-Handicapped). As in the Primary Curriculum, this unit is studied first on the premise that self-understanding must precede the understanding of others. In the intermediate program, the normal functions of the body systems are studied prior to the deficiencies caused by disabling conditions. An example, at the fourth grade level are the units on the Physiology of the Eye and The Physiology of the Endocrine System which are studied in preparation for the disabilities units of Blindness and Diabetes. This portion of the program is related to the cognitive development of the students in the areas of handicaps.

At each grade level, topics were paired according to the cause-effect relationship of handicaps. For example at the fourth grade curricula the units on Blindness and Diabetes are linked because of the correlation factor. Diabetes being the number one cause of blindness.

As one examines the fifth and sixth grade units reading through the introduction and concepts, one can see the correlation of the selected topics at each grade level.

The intermediate program builds the necessary foundation of knowledge which culminates in the Junior High curriculum.

Units at the fourth grade are: Physiology of the Eye, Blindness, Physiology of the Endocrine System, and Diabetes. (Show overhead #2b) Fifth grade units are: Physiology of the Ear, Deafness, Physiology of the Oral Mechanism and Speech Impairments. (Show overhead #2c) Sixth grade units are: Physiology of the Central Nervous System, Epilepsy, Basic Anatomy and Physical Handicaps. (Show overhead #3a). At the Junior High level, the seventh grade program follows the sequential format established in the intermediate program. In the unit entitled Cerebral Function, the normal processes of the brain are studied prior to the dysfunctions. This portion of the program is preparatory for the disability units and is related to the cognitive development of the students in the area of handicaps.

The disability units are: Mental Retardation, Learning Disabilities and Emotional Problems. Mental Retardation is presented first in order to illustrate the severe deficits which occur when the cerebral system is only capable of minimal intellectual functioning.

The Learning Disabilities unit was selected to follow Mental Retardation to illustrate the sharp contrast of mild process interference as opposed to minimal itellectual functioning as in the case of retardation. The concluding unit, Emotional Problems was selected to demonstrate the effect mental strain or fatigue can have on an individual's ability to function. The reason for correlating this unit is that severe emotional problems can produce a functional form of retardation. **(Show overhead #3b)**

The eighth grade program differs from the format used at preceding grade levels. The Review of Disabilities and Rehabilitation unit reviews the handicaps previously studied while focusing on available rehabilitation procedures. The disabilities in this unit are: Blindness, Deafness, Physical Handicaps, Diabetes, Speech Impairments, Epilepsy, Learning Disabilities, Mental Retardation and Emotional Problems.

Health Careers is the concluding unit for the eighth grade program. This unit is designed to make the students aware of career opportunities available in occupations involved with the diagnosis, treatment and rehabilitation of the aforementioned disabilities. To facilitate the study of Health Careers, the occupations are divided into medical and non-medical ones.

The Junior High curriculum continues the affective and cognitive development of the students initiated at the primary and intermediate levels. The curriculum culminates at the eighth grade with a review of the disabilities, study of rehabilitation for each disability and health careers related to handicapped and non-handicapped individuals.

Project C.H.A.N.G.E. was designed as a health curriculum and at the Primary Level meets all the requirements of a basic health program. At the Intermediate and Junior High levels it is designed to be used as a supplemental health program covering approximately an eighteen week time span, (one plan a week for four months). Although it is labeled a health program the Project C.H.A.N.G.E. curriculum can easily be used in other instructional areas such as Social Studies, Science, Language Arts, etc.

The curriculum was designed to be taught once each week; this may be changed depending on individual situations. The Primary Level Curriculum can be used for an entire school year with each unit covering a four to five week time span. At the intermediate level each unit will cover a time-span of three to five weeks. At the seventh grade, each unit covers a time span of three to five weeks. The Review of Disabilities and Rehabilitation unit for eighth grade covers eleven weeks (at least one week is devoted to each of the nine disabilities reviewed). The units on Acceptance of Self and Others (handicapped and Non-Handicapped), and Health Careers are three and four weeks respectively.

A Teacher's Manual for each grade has been developed. The manuals for each grade are divided into the units studied at that grade level. For example, the fourth grade manual would have five units one for each of the topics studied; Acceptance of Self and Others Physiology of the Eye, Blindness, Physiology of the Endocrine System, and Diabetes. Each unit includes: (Overhead #4).

1) An introduction which briefly explains the unit and lists the objectives and concepts to be taught in that unit

The introduction provides the rationale and basic background information for the unit. The behavioral objectives state the desired student response/outcome for unit completion. Basic concepts are provided to further clarify each objective.

2) The Activities section is composed of a series of lesson plans. Each lesson plan includes:

    1. Objectives - what the student should be able to do when the activity is completed.
    2. Materials - what is necessary to teach this lesson.
    and a 3. Procedure - specific suggestions on how to conduct the class activity or utilize films, filmstrips, and books.

3) Bibliography which lists films, filmstrips or books to be used with the unit.

The lesson plans in each unit are the "how to do it" part of the curriculum. Teachers may choose which specific lesson plans to use when presenting a unit to the student. Other materials which correlate with the objectives and concepts of the unit may also be used or developed. The choice of materials and activities should be based on the objectives of the unit and the individual needs of the class. The lesson plans include various types of activities: (Overhead #5)

1) Ingenuity activities - puzzles, matching exercises and various types of activity pages for the students to complete (copies of these should be distributed to each student).

2) Simulation Activities - during these activities the students experience what it's actually like to be handicapped by using a method to simulate a handicapping condition. This might be achieved by activities such as trying to pour water into a cup or find the classroom door while blindfolded. These activities help the students to understand the problems a handicapped person encounters in daily living. They also establish a basis for acceptance by fostering the development of empathy for the disable person. All students should have an opportunity to participate in simulation experiences. They should also be encouraged to think about and describe how it feels to be handicapped.

3) Lectures - for some topics, prepared lectures have been chosen as the best form of presentation. The lectures are based on the concepts and objectives for the unit. Through this format, medical terminology has been reduced to an understandable level for teachers and students while maintaining the predesigned program criteria.

4) Class Discussion - students should be encouraged to ask questions and talk about their feelings. It is important to accept all feelings-even negative ones. Rather than judge students' feelings the teachers should help the students to discover why they have a particular feeling.

5) Films, filmstrips, and books - lesson plans using films, filmstrips, and books are included. These materials help the students to better understand handicapping conditions.

After viewing the material, discussions should help students to achieve the objectives. The lesson plans contain specific directions for use of audio-visual material. These materials are yet another method for developing empathy.

These materials will be housed in the Learning Center (unless the designated Project C.H.A.N.G.E. staff decides to keep them somewhere else). The Project C.H.A.N.G.E. Media Assessment List can be consulted for a description of the films, filmstrips, and books that are available for the various topics. This Media Assessment List is also a guideline for processing new materials to be incorporated into the units. All materials in this list have been previewed by the Project C.H.A.N.G.E. Producer Staff and deemed exemplary in illustrating the concepts and objectives of each unit. Materials are listed by grade levels and topics. The Bibliography Cards can be checked to determine which filmstrips and books have been purchased for use with the program.

6) Speakers - (probably the most important and enjoyable activity of the program) provide an opportunity for students to interact with handicapped people. This experience allows the students to perceive the handicapped person as an individual with feelings, needs, talents, and problems similar to themselves.

The Project C.H.A.N.G.E. Resource File lists speakers and agencies (alphabetically by disabilities) that may be contacted and asked to speak. These speakers have been previewed by the Project C.H.A.N.G.E. Producer Staff and are highly recommended. This File is housed with the Project Co-ordinator. In most districts the Project Staff will arrange for some speakers.

Teachers desiring more background information concerning a specific topic may request to use the Teacher Training Manual housed with the Project Co-ordinator. The Teacher Training Manual contains the scripts for the training session. It also contains an outline of the training scripts, a vocabulary list, a fact sheet, a reference list and handouts.

The Readability level in each of the worksheets varies from two years below the grades for which the sheet was designed to a half year above the grades listed. Therefore, the majority of the students (with some assistance on terms) should be able to read the worksheets.

Much of the terminology is complicated and difficult to pronounce. It is not important for students to correctly pronounce terms in order to identify them or to read the material around them. If a term seems bothersome tell the student to call it blank or blank and match or read as needed. For word puzzles the student should be able to locate the word or tell it is on a crossword puzzle by process of elimination even though they may not be able to correctly pronounce it. Worksheets can be done orally, in a group or in partners.

Project C.H.A.N.G.E. was designed for the non-handicapped student to learn about normal development and the delays in the normal process of learning which can be caused by a disabling condition. Special Education teachers are encouraged to have their students participate in Project C.H.A.N.G.E. In the producer district this has been accomplished by allowing the special education teacher to select the grade level program which best meets the students' needs. For example, one intermediate Severe Learning Disabilities (S.L.D.) class participated in the fourth grade program. (Most of these students were at the fifth and sixth grade chronological age level). Once the special education teacher has chosen a grade level program the students should be allowed to participate in all activities and hear all guest speakers at that grade level.

This session is concerned with presenting a general overview of the curriculum and its mechanics. To facilitate a closer examination and discussion of the curriculum it is best to divide into three groups according to grade levels. Kindergarten through third grade teachers will meet to review the Primary Level Curriculum. Fourth, fifth and sixth grade teachers will review the Intermediate Level Curriculum and seventh and eighth grade teachers will preview the Junior High Curriculum. This will give everyone a chance to closely look at the curriculum on a specific grade level and discuss any questions they may have with a district staff member.

DEMONSTRATION SITES USING ASSESSMENT INSTRUMENTS

Before entering Small group sessions determine if any of the following information should be presented.

If your district has agreed to use the lesson plan checklist, the unit evaluation, or any of the following assessment instruments present the information listed under the appropriate title. This information can be illustrated through the accompanying overhead transparencies.

A. Lesson Plan Checklist - (Show Overhead A)

This form is located at the end of each unit. Write the title of the lesson plan which was taught on the line provided next to the appropriate date or week. The rating code which appears on this form is to be used in evaluating the activity. The Lesson Plan Checklist was designed as an evaluation to aid the Producer school in revising lessons.

B. Unit Evaluation Form - (Show Overhead B)

The Unit Evaluation Form is located at the end of each unit. This form should be completed at the conclusion of each unit. Select one lesson which was taught and evaluate it on this form. Write the Unit title on the line provided. (e.g.-Senses - Kdg.). The Activity title which is found on the lesson. (e.g. - Hand, Hand Hand, Game). Next to the Objective write the objective as it is stated on the lesson plan. (The students can identify various body parts).

The Outcome refers to the student's reaction, the teacher's reaction and pertinent comments about the lesson. (Students enjoyed this activity as they are able to be physically active).

Next to Evaluation state simply whether or not the lesson was successful in implementing the objective. (The lesson met the objective). Under the Evaluation of Activity answer the three questions. The Unit Evaluation Form assists the Staff in improving the program.

C. Assessment Instrument - Students - (Show Overhead C)

Primary Attitude Survey

The Primary Attitude Survey is an individual multiple choice (5 option) thirty item instrument designed to provide an estimate of a non-handicapped subject's attitude toward handicapped individuals. A non-verbal-motor response (printing to the picture plate) is the only requirement of the subject. This instrument is not timed but generally requires seven minutes per child, after the pre-training session.

The Primary Attitude Survey is most efficiently administered by a team consisting of parents, volunteers, etc. trained by the staff.

Skill Attainment List - Primary Grades

The Skill Attainment List is an individual twenty-eight item checklist designed to measure the student's cognitive gains in terms of grade level objectives and concepts. An oral response is required of the subject. The most effective manner of administration is using a team consisting of parents, volunteers, etc trained by the staff.

Intermediate Attitude Survey - Grades 4-6

The Intermediate Attitude Survey is a thirty item four choice group questionnaire administered by the classroom teacher.

This instrument is designed to measure attitudes of non-handicapped students toward handicapped individuals in the following areas:

I physical appearance
II personality traits
III expectancy
IV marriage
and V emotional capabilities

Junior High Attitude Survey - Grades 7-8

The Junior High Attitude Survey is a twenty-five item four choice group questionnaire administered by the classroom teacher.

This instrument is designed to measure attitudes of non-handicapped students toward handicapped individuals in the following areas:

I physical appearance
II personality traits
III expectancy
IV marriage
and V emotional capabilities

Skill Attainment List - Grades 4-8

The Skill Attainment List is a group multiple choice (4 option) thirty item instrument designed to measure the concepts of the curriculum objectives at each grade level. The instrument is administered by the classroom teacher.

Survey of Disabilities - Teachers

The Survey of Disabilities is a timed (no more than 30 minutes) fifty item multiple choice (four option) group instrument designed to measure the specific areas of disabilities covered in the curriculum.

Attitude Toward Disabled Persons (ATDP)

Yuker, Block and Younng, Human Resources Center, New York, 1970

The ATDP is a thirty item six choice group questionnaire designed to measure attitudes toward disabled persons as a group.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA
PRESENTATION OF CURRICULUM FACT SHEET

1. Program materials are stored in boxes marked according to units per each grade level.
2. Materials are housed in the Learning Center and may be checked out by the teacher signing the sign out card located on the top of the unit box.
3. A copy of each worksheet is in the Teachers Manual and should be duplicated by the teacher per the number of students in the class.
4. If the district staff doesn't contact guest speakers, teachers may arrange for speakers to visit their classroom following appropriate building policies. Teaming with other teachers at your grade level will assist in limiting the number of guest speakers entering the building and making full use of the guest speakers valuable time. The Resource File is an excellent guide for contacting speakers.

PROJECT: C.H.A.N.G.E.
TITLE IV C - ESEA

ROLE DESCRIPTION FOR CLASSROOM TEACHER

The Classroom teacher will be responsible for the following:

1. Participating in the teacher assessment program (Survey of Disabilities and the ATDP) pre and post the Teacher Training Program

2. Attending the Teacher Training Program

3a. For Intermediate and Junior High Teachers

Testing students (pre and post) per the district schedule with the project assessment instruments.

3b. For Primary Teachers

Cooperating with the Parent Test team on the pre and posttesting of students using the project assessment instruments.

4. Obtaining program materials from the learning center for implementation of lessons.

5. Duplicating program worksheets for students

6. Instructing the students (per district schedule) using the Project C.H.A.N.G.E. Teachers Manual.

7. Completing one Lesson Plan Checklist and Unit Evaluation per unit in the curricula

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

PROGRAM DESCRIPTION

Level: Primary
Grade: K thru 3rd
Units: Normal Health
Senses
Acceptance of Individual Differences
Disabilities: Blindness
Deafness
Physical Handicaps
Acceptance of Handicaps

Level: Intermediate
Grade: Four
Units: Acceptance of Self & Others
(Handicapped & Non-Handicapped
Physiology of the Eye
Disability: Blindness
Physiology of the Endocrine System
Disability: Diabetes

Level: Intermediate
Grade: Five
Units: Acceptance of Self & Others
(Handicapped & Non-Handicapped)
Physiology of the Ear
Disability: Deafness
Physiology of the Oral Mechanism
Disability: Speech Impairments

Level: Intermediate
Grade: Six
Units: Acceptance of Self & Others
(Handicapped & Non-Handicapped
Physiology of the Central Nervous System
Disability: Epilepsy
Basic Anatomy
Disability: Physical Handicaps

Level: Junior High
Grade: Seven
Units: Acceptance of Self & Others
(Handicapped & Non-Handicapped)
Cerebral Function
Disabilities: Mental Retardation
Learning Disabilities
Emotional Problems

Level: Junior High
Grade: Eight
Units: Acceptance of Self & Others
(Handicapped & Non-Handicapped
Review of Disabilities and Rehabilitation
Health Careers
(Handicapped and Non-Handicapped)

PROJECT: C.H.A.N.G.E.
TITLE IV C ESEA

READABILITY STUDY

NANCY UPDEGRAFF
READING CONSULTANT

Since readability formulas (Dale, Chall, Fry, Spache) require a minimum number of 250 words the following sources were used to determine a readability formula;

Dolch 220 Word List
Primary 330 Word List
Intermediate 100 Word List
San Diego Quick (assessment)
Schonell Graded Word List
Slossen Graded Word List
and the Manuals for Ginn 360
Levels 2-12, Word Lists.

In each of the work sheets the readability level varies from two years below the grade for which the sheet was designed, to a half year above the grade listed on the top of the sheet. Therefore, the majority of the students (with some assistance on terms) should be able to read the worksheets.

Much of the terminology is complicated and difficult to pronounce. It is not important for students to correctly pronounce terms in order to identify them or to read the material around them. If a term seems bothersome tell the student to call it blank or blank and match or read as needed. For word puzzles the student should be able to locate the word or tell it is on a cross word puzzle by process of elimination even though they may not be able to correctly pronounce it. Worksheets can be done orally, in a group or in partners.

ABOUT THE STAFF

STAFF:

Director	Donald Martin
Coordinator	Sherry Smith
Assistant Coordinator	Alan Balter
Medical Consultant	LaVerne Galzin
Media Consultant	Cynthia Foulkes
Curriculum Coordinator	Karen Harper
Curriculum Advisor	Kathleen Delaney
Curriculum Advisor	Robert Honkisz
Graphic Artist	Karen Madden
Evaluation Consultant	A. Edward Ahr

Donald Martin, Project Director, holds B.A. and M.A.T. degrees from Harding College in Arkansas. He has worked as Assistant Principal at the Junior High School level, Director of a Demonstration Center for Gifted Children, and as Director of Federal Programs. As Program Director for Project C.H.A.N.G.E., he is responsible for the overall administration of the project.

Sherry Smith, Project Coordinator, has the B.A. from College of St. Francis in Illinois and M.S. from Chicago State University. Her previous experience includes classroom teaching and speech pathology at the elementary level. As Coordinator of Project C.H.A.N.G.E., she is responsible for the day-to-day operation of the program including grant writing, curriculum planning, and design of assessment instruments.

Alan Balter, Assistant Project Coordinator, has B.S., M.S., and Ph.D. degrees from the University of Illinois. He has worked as a teacher of retarded children, researcher, and university professor. As Assistant Coordinator, he helps with the daily functioning of the program and project dissemination.

LaVerne Galzin, Medical Consultant for the project, is a registered nurse who also holds the B.S. degree. She has wide experience working as a hospital nurse, public health nurse as well as a school nurse. In her role as Medical Consultant she explains nursing and medical information and strategies to program staff and is the program laisson to the medical profession.

Cynthia Foulkes, Media Consultant for the project, holds the B.S. in Education from Illinois State University and the M.S. in Education from Chicago State University. Her experience includes working as a School District Librarian and Director of a Learning Resource Center. She is responsible for ordering and processing all program materials as well as assisting program staff plan and execute audio-visual presentations.

Karen Harper, Curriculum Coordinator has the M.A, degree in Learning Disabilities and has many years of teaching experience in special education. She has developed the Kindergarten and Primary grades curriculum and supervised curriculum development at other levels.

Kathleen Delaney, Curriculum Advisor, has a B.A. degree from St. Xavier College in Illinois. She has worked as a teacher's aide in Project Head Start and as a teacher in the elementary grades. Her major responsibilities have been writing the project curriculum and lesson plans for grades 4-6.

Robert Honkisz, Curriculum Advisor, has the B.S. degree from the University of Illinois. He has worked as a physical education teacher in the elementary grades. His primary responsibilities have been writing project curriculum and lesson plans for grades 7-8.

Karen Madden, Graphic Artist, holds the B.S. degree from Northern Illinois University and the M.S. from Illinois Institute of Technology. She works as an Art Teacher for children between Kindergarten and 8th grade. Her major responsibility for the project involves producing original artwork for program materials.

A.Edward Ahr, Evaluation Consultant, has the B.S. and M.S. degrees from the University of New Mexico and the Ed.D. degree from Loyola University in Chicago. His work experience includes classroom teaching, school psychology, school administration and university teaching. His project responsibilities involve designing assessment techniques, statistical analysis of data and program evaluation.